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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Staff Use in Child Welfare

Blind Children With Problems

Dental Care for the Handicapped

Licensing for Foster Care

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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A MOMENT OF RELAXATION. One of the many thousands of children whose mothers work outside the home, this child seems to feel comfortable in the care provided in a licensed day care center. What kind of protection such children need and how it might be provided were the subjects of intense discussion at the recent National Conference on Day Care for Children held in Washington last November. (See page 33.) The conference will be reported on more fully in the March–April issue of CHILDREN.

◀ *the authors*

Since coming to the Children's Bureau in 1943, Bessie E. Trout has been concerned with the education, training, and effective use of personnel in child welfare. Previously she had directed the child welfare staff development program for the New York State Department of Social Welfare. She began her career as a rural child welfare worker after graduating from the New York School of Social Work.

Pauline M. Moor's responsibilities at the American Foundation for the Blind are concerned with services to young blind children and their parents. Before joining the staff of the Foundation, she worked on a research program for the study of retrolental fibroplasia under the direction of the late Dr. Theodore Terry of Boston, who defined this condition. She began her association with blind children as a teacher.

Author of numerous articles on dentistry and bacteriology, Don Chalmers Lyons practices dentistry in Jackson, Mich. Besides his association with the W. A. Foote hospital, he is dental consultant for the Mercy Hospital and for a crippled children's camp. For 25 years he has been dental abstractor for the journal, *Biological Abstracts.*

Neither Lee Headley (left) nor Hazel Leler (right) is now connected with the program they describe. Mrs. Headley is practicing social work privately in Palo Alto, Calif., and is a consultant on group psychotherapy for a number of agencies. Mrs. Leler, now "at home with a new baby," is trained and experienced in both social work and parent education.

In their collaboration, psychiatric social workers David Hallowitz and Katharine Pitkin and psychiatrist Albert V. Cutter illustrate the kind of team approach that is characteristic of a child guidance clinic. Mr. Hallowitz, also an educator, teaches at the New York College of Education at Buffalo. Dr. Cutter is on the faculty of the University of Buffalo Medical School. Before going into social work, Mrs. Pitkin was a correspondent for the *London Economist.*

Professor Norris E. Class (left) has worked in both State and local licensing programs and recently participated in the California welfare department's staff development program for licensing personnel. Gertrude Binder (right) has had licensing experience both in New York and California. She is presently concerned with regulations for hospitals and institutions for the aged.

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Coming to grips with personnel shortages has brought some replanning in . . . . . .

THE USE OF STAFF IN CHILD WELFARE SERVICES

BESSIE E. TROUT

Specialist in Staff Development, Children's Bureau

AS THE CONTINUOUS threat of conflict in today's world mobilizes our efforts for survival, the Nation's attention tends to focus on the physical sciences as the source of advances in technology and the development of weapons for defense. As these needs are constantly kept before the public through the mass media of communication, the importance of human assets and values and of people themselves in dealing with national and world problems tends to be obscured. This is reflected in personnel shortages today in every profession whose function is to serve people, whether it be medicine, nursing, teaching, or social work. In social work the gap between positions and people qualified to fill them is particularly acute.

The scarcity of professional personnel in social work, however, has existed for a long period of time, and obviously has other reasons behind it besides the competition with the physical sciences. Among them perhaps is the fact that social workers have not been as articulate in making known the purposes and the rewards of their profession. Characteristically in our culture we minimize the good we do. More frequently, we emphasize the practical and the material rather than the deep personal satisfactions derived from being helpful to people and from developing one's own talents. Good salaries would, of course, be important in attracting people to the profession. But achieving these in any profession, in the last analysis, depends upon public acceptance, understanding, and support.

Efforts in recruitment for social work that interpret the meaning of the profession more fully to college students and communities have demonstrated that when the story of social work is told, persons considering a career respond to its potentialities. Special projects both in large metropolitan areas and in sparsely settled rural areas have resulted in an unexpected number of young people taking steps to enter the profession.

What the public generally has not been made to understand has been what the effects of inadequate personnel in these services mean in the lives of people and hence to the human resources of the Nation. The public hears about the effects of shortages in professions such as medicine, nursing, or teaching, but it is not so aware of what the inadequacy of social work personnel may mean. Moreover, the crowded schoolrooms that result from teacher shortage and the effects on a hospital of a lack of nurses are immediately visible and therefore more generally understood than are the results of inadequate or no social service to a child whose family cannot or fails to provide him with the care he needs.

In the child welfare field, social work staff shortages are general, but they are most acute in the public welfare agencies where demands for services are urgent and diverse.

What is the effect of staff shortage on child welfare? In many communities some essential services to children and their families are now given only on a selective basis. The need for services to prevent problems from arising is even less recognized, and, therefore, these services are even more frequently lacking. Some once good services have been weakened through pressures resulting from lack of personnel, such as high caseloads, the use of staff lacking the necessary qualifications to carry out the assignments given to them, or spreading the services too thin.

Social agencies often see the tragic consequences of this weakening of services. Families who with the help of a child welfare worker have achieved a higher level of functioning fall back into old patterns when the worker is withdrawn too soon because of agency pressures. Confusion as to what social work really involves has been created in some communities by the adaptations agencies make in administering a professional service without the staff it requires. This dilution of a professional service may haunt social service programs for years to come.

But what do these limitations on services mean to children? They may mean that when a child has lost his parents and needs a permanent family by adoption he is placed in "temporary" group care, which inadvertently becomes permanent. As the shortage of staff continues, the child, lacking the attention he needs, is "building in" insecurities that stay with him through the years.

Staff shortages may mean that an adolescent who has no guidance at home gets into trouble with the law and is adjudged delinquent by the children's court. Had personnel been available to help the child and his parents earlier, this might not have happened. A social worker might have helped the parents to develop strengths to handle the situation or the community to see that the child's environment was not conducive to his normal development.

An agency worker unequipped for the service to be rendered may be used by an agency in lieu of adequately prepared personnel. As a consequence a child may lose his home unnecessarily because the worker does not have the skills to help the family draw on its own strengths to give the child the care he needs.

Division of Labor

Obviously one way to avoid the serious effects of staff shortages is vigorous recruitment. But efforts to recruit new personnel to the profession cannot completely answer the problem of staff shortages. The shortage of professional personnel has forced most major professions to consider the *use* of staff—to analyze what knowledges and skills go into the various aspects of the total job to be done and to determine the different kinds of staff this requires. The shortage of personnel in the service professions has therefore not been altogether an "ill wind."

As a result one can detect a common movement within them. They are moving away from a practice in which one person does the total job, to a breaking down of the job into its parts, with an overall responsibility vested in the professionally trained person. This concept in industry brought the Industrial Revolution over a century ago. No longer does one man make a table. For many years it has been followed in the field of medicine. The doctor no longer does everything that needs to be done, but has reserved for himself those parts of medicine that require his professional knowledge and skills, delegating to a nurse or a laboratory technician or others things which require other kinds of skills.

The professions of nursing and education have approached the problem of staff shortages in a similar way.

The professional associations of nurses have analyzed the content of nursing and defined what part must be done by the professionally equipped nurse, what can be done by the practical nurse, and what by the nurse's aide.

In the field of education some educators have begun to analyze the components of the educational process to identify those aspects which require the knowledge and skill of a professionally equipped teacher. They have also examined areas in which other skills than teaching may be used effectively to enrich the quality of teaching. For example, they found that while the teacher-pupil relationship is an essential part of the teaching function requiring the knowledge and skill of the professionally equipped teacher, there are tasks, such as reading of themes, that can be carried out in part by the teacher and in part by a lay reader. A plan has been proposed providing for and integrating the functions of the teacher, instruction assistants, general aides, clerks, community consultants, and staff specialists.[1]

In the field of social work the tasks requiring different personnel qualifications have been more clearly differentiated in other countries—in all stages of development—than in the United States.

Following is a brief excerpt from a United Nations report:[2]

> The shortage of professionally qualified social workers is almost universal. Therefore, the need for auxiliary and community workers arises in the first instance from lack of a

> sufficient number of professional personnel. By entrusting certain functions to auxiliary workers, it is possible to spare professional workers for tasks in which their technical competence can be used to the best advantage. This problem exists not only in countries with practically no clearly structured and well-established social welfare provision, but also in those with a highly developed and complex range of such services.
>
> The employment of auxiliaries is often taken to be a concession to necessity, with the implied suggestion that the services in question should be staffed by professional social workers if and when these become available. It is, however, also argued that in any country there is some straightforward work which could be satisfactorily carried out by auxiliary workers, provided that adequate methods exist for identifying needs or situations beyond the competence of such workers to meet.

These words have particular significance for social work in the United States. The principle basic to the staffing problem is *first*, to clarify the professional component in service and *second*, to define those aspects of the services that do not require professional knowledges and skills, but may require other skills, many of which may be developed on the job.

Child Welfare Experiments

The professional nature of child welfare services has been a major strength in the program. But in child welfare, as in the early stages of other professional services, the professional worker has been expected to do the total job. Now under the impact of staff shortages, some efforts are being made to look at the parts of each service provided in a child welfare program as well as at the whole.

Child welfare agencies have had to scrutinize their service to discover how they could maintain and develop not only coverage but also, and perhaps even more important, quality. This has made it necessary for them to analyze the service to find out not only what knowledges and skills are required for carrying it out, but also how each component of the service can make its maximum contribution to meeting the needs of the people served.

A few child welfare agencies, most of them voluntary, have for several years been experimenting in this kind of analysis and have reorganized their staffing practices in accordance with the results. Usually this has been carried out as a gradual process of experimenting in one phase of work.

As in any profession, in social work, examination of the kinds of knowledges and skills necessary for practice requires a clear understanding of the unique contribution of the professional worker. This contribution is sometimes more readily recognized than defined. In social work the core of the professional contribution is regarded as lying in the conscious use by the worker of a relationship with an individual in determining and meeting his needs. In this professional relationship the worker calls on a background of knowledge of the dynamics of behavior; a recognition of personality disorders, an understanding of when and how to use resources, and an ability to think and feel with another person—to listen with a disciplined mind and trained ear in evaluating the significance of what is said—in guiding an interview, and in eliciting information necessary for understanding needs and strengths. All of this involves continuous evaluation, diagnosis, and decision making.

In evaluating the kinds of knowledge and skills that are required in any aspect of child welfare services, it is necessary to distinguish between tasks that appear similar but which are different—for example, interviewing for diagnostic and treatment purposes that require professional skills, and interviewing for informational purposes which does not require professional knowledge and skills.

In child welfare the use of nonprofessional staff for nonprofessional tasks is still in an exploratory stage. More experimentation in a variety of settings is urgent before a pattern for their use can be obtained, but the experimentation that has already taken place has provided some interesting leads.

While the professionally trained worker carries basic and continuous responsibility for service to the child, the family, and foster parents, the case aide is being used to "work up the case." For example, securing information from court records, from the records of health agencies or social agencies, or arranging appointments at clinics can be handled by the worker without professional social work skills. Case aides are usually college graduates and may have skills other than in social work. Often they are people who have not yet chosen a career.

One voluntary agency recently gave a case aide responsibility for arranging camp placements for 90 children under its care. The aide visited the camps in the area, became familiar with the camp life, the kinds of experiences the children would have, the equipment they would need, and the forms and reports required by camps, such as medical histories. The agency found that the case aide developed an appreciation of camp life as an experience for children which its busy social workers ordinarily did not develop.

In another voluntary agency, a case aide who had majored in sociology was given the assignment of learning what resources for children and their families existed in the community—old ones, new ones—and gaps in services. This project not only proved to be tremendously valuable to the agency in discovering resources it had not known existed, but also helped to improve its community relationships, as other agencies became enthusiastic about the agency's having one person responsible for continuous contact with them. (These contacts did not take the place of the agency's usual administrative contacts with other agencies.) Thus the case aide was able to develop unusual skill and a body of knowledge that contributed to the improvement of total agency services.

A similar project in a small rural public child welfare agency focused on discovering what recreational opportunities for youth existed in the community in an effort to learn whether their lack was a factor in the increased delinquency in the area. This proved valuable to the agency, the court, and other community agencies.

In one voluntary agency case aides have also been given responsibility for keeping the "health schedule" for all children under care in order to see that health examinations are made and transportation planned for. They have also been made responsible for keeping in touch with all prospective foster parents and adoptive parents waiting for agency action in order to prevent loss of their homes for the agency's children. Since the cost of each study of an adoptive home was estimated by this agency to be $1,000, this practice was regarded as a sound administrative measure.

Experience thus far in the use of case aides points to the importance of individualization in making assignments and also in having these made by a professional person who knows the nature of the task. For example, if a child must go to a clinic the question of who takes him is determined by what is needed. If the child is insecure and fearful and the professional worker is trying to win his trust and confidence, then the trip to the clinic is used by the professional worker as a part of her plan of treatment. If the child is established and secure in his own home or in a foster home, and unafraid of the visit to the clinic, then all that he needs is transportation by a friendly person, and the task is assigned to a case aide.

One agency executive who has used case aides for several years has noted that many of the families served by the agency—especially those who have long been socially and emotionally deprived—have benefited by having contacts with a number of different people from the agency. The agency sees value for the families in having more than one person show his respect for them, give them emotional support, and accept them as they are. The agency also sees a value for the children in having an opportunity to trust and respond to a broader range of people.

Danger in Expediencies

In the public child welfare agencies, however, not much more than fragmentary experimentation has been carried out in analyzing job functions as a basis for relating the workers' knowledge and skills to the task to be done. The magnitude of the problem of staff shortages coupled with the agencies' legal responsibility for children who cannot be cared for by their families has created heavy pressures for resorting to expediencies. This accounts for much of the current practice of using nonprofessional personnel to carry professional responsibilities.

Various modifications of this practice have been made in an effort to protect the quality of services. Often nonprofessional workers are assigned to cases in which the problems are not complex, their caseloads are kept comparatively low, and supervision and on-the-job training are provided from professionally qualified staff. But in spite of these protections, this use of staff is attended by many problems.

One is that the term "untrained worker," generally in use, implies low status, but it does not indicate the nature of the responsibilities the worker carries. In other professions and in social work in other countries, titles for agency personnel almost always are set up to indicate the nature of responsibility the worker assumes. The title of "practical nurse" or "nurse's aide" indicates an area of competence, similarly a "laboratory assistant" is not an "untrained" technician. Obviously the development of appropriate titles for nonprofessional child welfare staff depends on a clarification of the functions these workers are to perform.

The problem causing the greatest concern, however, is the degree to which the agency can provide the quality of service that meets need. Little research has been done to examine the contribution of nonprofessional workers as compared with professional workers. However, some agencies on the basis of their experience are beginning to question the assumption that well-qualified supervision for nonprofessional workers can protect the child and his family from the potential hazards of being assigned to an untrained worker. They are beginning to realize that the supervisor's ability to evaluate or make judgments is based largely on the information brought to her by the worker who, if untrained, may miss the insights so significant in work with people. These agencies are changing their practices to comply with the concept that the core of the agency's service lies in the interviewing process and the ability of the interviewer to understand troubled people and their problems, to see their strengths and to help them build on these—a process requiring professional competence. If this concept is valid, a supervisor cannot substitute for a professional worker who has direct contact with the individual.

In one State child welfare program plans are underway to reorganize the staff assignments in adoption and arrange for professional staff within a district office to be responsible for interviewing and for carrying overall responsibility for the case. The nonprofessional staff will be used for carrying out other aspects of the service, such as the securing of health information and the legal records required for adoption and seeing to the details of various kinds of arrangements.

Another State agency is reorganizing its overall plan for providing child welfare services and is placing professionally trained staff in regional offices to work with nonprofessional workers in local offices.

Even in these beginning steps in staffing, a potential exists for the use of a team similar to the teams proposed in the field of education.

A team in a public child welfare program which has no local professional staff might consist of a professional social worker in a regional office who assumes overall casework responsibility; a nonprofessional worker, or case aide in a local office, who assists the professional worker; the local administrator, who carries administrative responsibility; and perhaps a psychiatric or other special consultant. Different settings and problems will of course suggest different team membership, but at any rate the team approach furnishes a fruitful area for further exploration and experimentation.

Good administration avoids waste of staff talent and skills on activities that do not require them. Recently a young man professionally equipped in social work, a leader in his community and in his professional organization, speaking of his deep interest in working with people made the remark: "One thing is hard for me to accept; 50 percent of my work does not require my knowledge and skills." He was using his time on work that required the skills of a clerical person who, if available, could have made it possible for him to concentrate on areas where his services were badly needed.

In addition to increasing the quality of service for the individual client, division of labor greatly enriches the insights of the agency as a whole. This same principle applies to all differential assignments. The highest quality of service is achieved when the task to be done is in line with the worker's ability. A significant byproduct of allowing each worker to concentrate on problems that are within his competence is that the components of professional knowledge and skill become more clearly defined, thus making a feeling of accountability more possible for the worker and for the administrator.

Those aspects of the work that do not require the knowledge and skills of professional social work take on a new importance as a necessary part of the agency's total objectives when assigned to workers who are interested in them. When carried out with imagination and creativity, each part of the agency's service has a meaning to the whole—a recognized and essential relation to the person being helped. The result of such division of labor is usually a boost in staff morale.

Studies Needed

The need for studying present patterns of use of staff and for experimenting with alternative methods is most urgent in social work. The beginnings of job analysis in the child welfare field have been small, involving usually no more than a few staff members in a given aspect of work. However, as experiments, they have not only met a need for individualization of the tasks of the service involved but also have provided some criteria that might be used in analyzing other services.

In addition to agency studies, there is promise of some guidance from the national level. In the social work profession, the Commission on Social Work Practice of the National Association of Social Workers has set up a committee to give attention to the most effective utilization of social works personnel. The medical social work committee of the association is also working on the problem and is developing criteria for determining whether or not a given task in medical social service requires social work education.

In the Department of Health, Education, and Welfare, the National Institute of Mental Health is supporting a number of projects, chiefly in hospitals, which are designed to clarify the use of the social work case aide in psychiatric settings. The Bureau of Public Assistance is engaged in a project on "Educational Standards for Functional Responsibilities." Its object is to establish standards for the educational background of specific job functions in public assistance.

The first published report of a research project on the use of the case aide in a social work setting appeared last summer, "A Study of Nonprofessional Personnel in Social Work—The Army Social Work Specialist" by Fergus Thomas Monahan.[3] This report sets forth the objectives of the agency, the kinds of assignments given to the nonprofessional personnel and their place in the agency structure.

Effects of Reorganization

Will differential assignment of staff substantially reduce the shortage of professional personnel? Experience does not justify a general answer. A few voluntary social agencies report that the caseloads of professional staff relieved of nonprofessional tasks have increased markedly, in one instance as much as 50 percent.

These agencies have concluded that they would not again employ social workers for all aspects of their services regardless of the number available. Rather, they have shifted their staffing goal to one of securing the various kinds of personnel needed, including professional and nonprofessional, to assure a maximum quality of service.

However, in agencies as severely understaffed as most public child welfare agencies, a redefining of tasks may show up even more the need for additional staff with social work education.

The Advisory Council on Child Welfare Services, provided for in the 1958 amendments to the Social Security Act, in its report of December 1959,[4] estimated that the number of additional staff needed in the public child welfare field by 1970 (considering only the increase in child population and geographical coverage) would approximate 12,000. How different organization and assignment of staff would affect this picture cannot be predicted. But obviously this calls for accelerated agency recruitment programs, expanded opportunities for educational leave, and sufficient agency funds to meet both educational leave costs and the cost of additional staff.

One of the larger States now has a statewide plan for expanding its professional staff; a goal of full professional training for all professional positions; and an annual assessment of the number and qualifications of existing staff, the numbers of professional staff needed, the numbers of new staff that can be absorbed in a year, the numbers of staff to whom educational leave will be granted, and the use to be made of such staff on their return. This plan will be followed until the goal is reached.

There are encouraging signs of a nationwide effort toward new approaches to recruitment. The Council on Social Work Education has for a number of years given leadership in recruiting for the profession. Now the council is in the early stages of developing an overall national plan for recruitment, on the grounds that the magnitude of the problem of shortages demands a plan of equal magnitude to meet it.

In the foreword of the Rockefeller report on education, "The Pursuit of Excellence," is this apt statement: "There is no more searching or difficult problem for a free people than to identify, nurture and wisely use its own talents".[5] The critical staff shortages in child welfare agencies demand increased effort to solve this problem.

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[1] Trump, J. Lloyd: Images of the future. National Education Association, Washington, D.C., 1960.

[2] United Nations, Department of Economic and Social Affairs, New York: Training for social work; third international survey. 1958.

[3] Monahan, Fergus Thomas: A study of nonprofessional personnel in social work; the army social work specialist. Catholic University of America Press, Washington, D.C., 1960.

[4] Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Report of the Advisory Council on Child Welfare Services. December 28, 1959.

[5] America at Mid-Century Series: The pursuit of excellence; education and the future of America. (Special studies project report V, Rockfeller Brothers Fund.) Doubleday & Co., Garden City, N.Y., 1958.

When we are concerned with children we cannot afford to have hardening of the categories.

Dr. Glenn Hawkes, Director of Department of Child Development, Iowa State University, to the National Conference on Day Care for Children.

BLIND CHILDREN WITH DEVELOPMENTAL PROBLEMS

PAULINE M. MOOR
Program Specialist, American Foundation for the Blind, New York

TODAY there are approximately 35,000 children and young people under 21 years of age in this country who are blind. Although the incidence of blindness in infancy has been sharply reduced since the relationship of retrolental fibroplasia to an oversupply of oxygen in the care of premature babies was demonstrated in 1953 and 1954, the children who suffered this condition are still with us, as are children whose blindness comes from congenital or other causes. Many of these children are growing and developing well, and are already engaged in educational programs or are about to enter school. There are, however, some children who have been blind since infancy, who are presenting grave problems to their parents and to professional persons interested in providing them with appropriate educational and social services.

The blind children who are presenting these difficulties may be said to be "multiply handicapped"; but their additional handicaps are of an intangible behavioral nature rather than an obvious physical disability such as a hearing loss or a crippling condition. When seen in physicians' offices, diagnostic centers, child guidance clinics, and speech centers they are variously described as being "autistic," "mentally deficient," "psychotic," "aphasic," "emotionally disturbed" and/or "brain damaged." Many of them have been denied admission to or have been dismissed from educational programs as being too immature, not fitting into the school, uneducable, unable to talk, or in need of more individual attention.

The meager professional literature about this type of child describes an easily recognized picture of a child often frail in appearance, lacking in muscle tone, and seemingly a victim of overprotection, understimulation, and overexpectation. The one characteristic common to all such children is their developmental retardation. In the preschool years the child may be slow in responding to the efforts of his parents to teach him self-help skills such as feeding, dressing, and toileting. Often a parent will report that he is sure the child comprehends but seems almost to be teasing the adult by not wanting to cooperate.

Another frequently observed characteristic is the child's lack of language for purposes of communication. Some nonverbal children are reported as having talked at one time, perhaps in the early preschool period, and as then having gradually stopped. Others may verbalize readily or repeat in an echolalic fashion much of what they hear: abrupt phrases, television commercials, and the like. Some children speak only in the third person, never using the pronoun "I." Others do not make any attempt to communicate verbally.

This lack of communication seems to supplement the autistic or withdrawing qualities often observed. A child may appear to be indifferent to persons in his environment by simply remaining passive and initiating little activity. On the other hand, he may slowly comply with the suggestion of an adult but exhibit no change or affect. A child may show little or no preference among adults; for example, he may take the hand of a stranger as readily as that of his parent, giving little impression of discrimination between persons.

This pose of unawareness or indifference to people is most pronounced when children with similar problems are brought together in a group situation. They may be alert to the presence of each other and at times disturbed even to the point of being jealous of attention, yet they do not necessarily communicate with one another.

In gross mobility, the child often seems extremely awkward, with apparently aimless movements of arms and legs. In contrast, finer motor coordination or dexterity may be well developed. Some children may exhibit a tenseness suggestive of a spastic condition; many of the blind have been at some time or another described as "slightly palsied." Toe walking is sometimes seen as well as a toeing outward and a stiff almost stamping tread.

Many of these children exhibit behavior patterns such as head banging, rocking, face slapping, and biting. An unusual rote memory has been noted often as well as a high capacity for recall as measured by psychological instruments. These rhythmic patterns plus the ability to recall tend to enhance the child's enjoyment of music, a characteristic often capitalized upon by the adults in their lives.

These children confront the professional worker with three major questions:

1. **How may this blind child's potentialities be adequately appraised or evaluated?**
2. **What may be contributing factors to the child's present development and is it possible to modify his retardation?**
3. **What kinds of services—educational, social, and psychological—are necessary to help him develop to his optimum potential?**

Appraisal

Most of the children presenting problems in addition to their blindness come to the attention of the professional worker as they approach school age. Though the child might have seemed to be retarded in development earlier in his preschool years, there was always the possibility that given enough time to grow and develop he would "catch up" with his peers by the time he should be entering school.

Many schools require a psychological examination of the child before or shortly after his enrollment, particularly if he has a physical handicap. In some instances the test score will determine the child's acceptance in the program. In others, it may be used only as one of the tools of measuring his development. Authorities in child development often regard children who are blind as presenting a difficult challenge as far as appropriate evaluation is concerned especially in the preschool years. Not only are the instruments of measurement considered inadequate, but the children themselves are apt to be deceptive in appearance and their performance to belie their true potential. Yet an evaluation should be helpful to those who will be planning for and working with the child.

Much variation has been observed in the appraisal process. Some children are evaluated on the basis of one appointment with the psychologist, plus as much supplementary information as may be secured. On the other hand, sometimes the child who presents problems may be seen in a residential setting from 2 to 10 days with a parent also present. Some authorities maintain that the child who is "difficult to evaluate" should be studied for a 6-month period, preferably on an inpatient basis, before any attempt at appraisal is made.

The examiner responsible for evaluating the blind child may feel inadequate if he is unfamiliar with some of the characteristic behavior and skills of a person functioning without sight, such as his use of auditory cues or methods of orientation in a new environment. Bauman has discussed some ways of working with the adult blind client which may be suggestive also for the person working with children.[1]

A complete history of the child's physical and emotional development during his first 5 years of life should be available to contribute to the evaluating process. If the child is entering an educational program, any report of early group experience, such as nursery school or kindergarten attendance, should add to the educator's understanding of the child's development. He will want to know, too, if the child has ever been hospitalized for any length of time, particularly in infancy when first relationships with people are generally formed. Moreover, such knowledge may be helpful in understanding the parents' feelings toward their baby.

Of special significance in planning for the child will be the ocular report indicating the cause of blindness, congenital or otherwise, and the length of time the child has had a visual loss. When interpreting the report one will note especially the age of the child at the onset of blindness and the amount of his visual acuity if there is light perception or more residual vision. Such information may help to explain why some of the child's concepts in certain areas may be weak.

According to studies of the development of children who are blind, behavior which in children with vision would seem to be symptomatic of mental deficiency, brain injury, or severe emotional disturbance must in a blind child be looked at not in relation to the development and functioning of the

Once regarded as having little educational potential, this blind child is now developing well under skilled guidance.

sighted individual, but in relation to its purposefulness or meaning to a person who is growing and functioning with little or no sight.[2]

For example, the examiner may be cognizant of the factors in the early life of the blind child which might have contributed to his passivity or autistic behavior, such as isolation in an incubator, the early attitudes of his parent toward his blindness, and evidences of emotional deprivation.[3] Or the examiner may note the motor activity of the child. Perhaps the child's stiff gait results from lack of early motor experiences. Perhaps his toeing outward and the slight stamp in his step may be part of his effort to get auditory cues for orientation purposes as he walks. The excellent memory of many blind children can be of real advantage to their functioning as blind persons and should not be regarded as a negative factor indicative of bizarre development.

The examiner will realize that some children refer to themselves in the third person because that is what they have always heard. He will also want to know how much life experience the child has had that could contribute to his development of a positive concept of self.[4]

As has already been indicated, the psychological instruments themselves are limited. At present the Interim Hayes Binet Tests for the Blind (1942 Revision) is the only standardized instrument for children who are blind.[5] Most psychologists agree that this test is not reliable for children under 6 and do not advise it for those over 12.

For the very young blind child the Maxfield-Buchholz Social Maturity Scale may be used. As the name implies, it is a measure of social maturity only. In using it the examiner is dependent upon the responses of the parent to questions concerning activities indicative of the child's development. The limitations of such a scale are obvious, as it is natural for parents to be anxious about their child's performance in relation to other children.

Blind children may also be examined with selected parts of certain standardized tests for sighted children, such as the Cattell Infancy Scale, the Wechsler Intelligence Scale for Children, and the Merrill-Palmer Scale. Again, many examiners will use selected portions of these instruments, depending upon the individual being evaluated.

Most blind children are able to cooperate with the psychologist during the tests, but those who present the most baffling problems sometimes do not respond in the normal test situation. Most evaluations, therefore, are the composite result of the observations and thinking of the psychologist, pediatrician, ophthalmologist, and social worker who know the child, supplemented by information furnished by the parents. Even with all this help, some children are singularly hard to evaluate for there is always the question as to whether one is dealing with true mental retardation or with a developmental retardation resulting from a multiplicity of factors, not the least of which is the traditional way of thinking about blindness.

Factors in Retardation

Many questions must be raised when a blind child exhibits signs of retardation. Does his retardation have a true biogenic basis? Is he slow to respond because he has been deprived, unwittingly, of learning experiences? Has his development been conditioned by the emotional climate in which he has been living? Has the sensory deficit, his blindness, contributed from infancy to the retardation by preventing him from using in the same way as a sighted person the neurological pathways ordinarily stimulated by vision.

For many years in the past blindness in a child was considered to be invariably accompanied by mental deficiency or with at least some degree of mental incapacity. Early literature indicates that the only care or attention given to blind persons was in institutions for the "mentally defective and the blind." Only in the last few decades have services been offered to blind persons on the basis of a consideration of their well-being. The realization by more than a few persons that the very young child who has severe visual loss may have excellent potentialities is even more recent. Even within the last decade parents of blind babies have frequently been told, "Your child is blind and perhaps the best thing to do is to put him away, forget about him, and have another baby."

Because more than 50 percent of the blind children born within the last two decades have a visual loss as a result of retrolental fibroplasia, a condition they acquired as premature babies, it has been easy to think of all blind children in terms of this diagnostic entity and, conversely, to think that the child who has retrolental fibroplasia exhibits characteristics common to all blind children. In consequence the adjective "retrolental" has for many people certain false connotations.

Studies by Hayes [5] have indicated no marked difference in the development of the child blind from retrolental fibroplasia and the development of children blind from other causes. Though oxygen has been found to be a significant factor in causing blindness in the premature eye, the studies of Krause and Patz [6,7] have seemed to indicate that only the eye was damaged. No evidence was found of neurological injury. However, prematurity does have its hazards and the same child may be a victim of some of its complications as well as of blindness.

Information pertaining to the cerebral activity of children blind from infancy is meager. Gibbs found the electroencephalogram pattern in blind children to be similar to that of brain-injured children.[8] However, it should be noted that 33⅓ percent of the sampling used in his study was drawn from a school for mental defectives. One should also bear in mind the fact that neurologists are apt to see blind persons only when they are institutionalized or are patients who have come to their attention because of questions in regard to their neurological functioning.

Though some neurologists report a spiked pattern characteristic of impairment, there are also reports of blind children with bizarre behavior for whom the electroencephalograms show no significant abnormalities. Parmelee found that the electroencepholagrams on six children, blind from retrolental fibroplasia, were "not diagnostically significant, though two were suggestively abnormal."[9] A more extensive comparative study of blind children in an institution for the mentally retarded and in a residential school reveals "no neurological impairment due to factors responsible for retrolental fibroplasia."[10]

General Observations

A study of numerous case records of blind children, including health reports, developmental histories, and material descriptive of the environment in which the children have been growing has led to the following observations:

1. These children represent a variety of social and ethnic backgrounds. Many children come from homes of "average" or "above average" socioeconomic status.
2. When informed of the diagnosis of blindness parents have nearly always been told that the child has a poor prognosis not only regarding the possibilities of vision but also in terms of anticipated development.
3. In many instances the diagnosis of blindness was made after the child was some months old. The parents presumably delayed taking their child to the doctor in the hope that their fears of a visual loss were unwarranted, or that the child would be able to see as in growing older he overcame the handicap of his prematurity.
4. Mothers frequently express more difficulty than fathers in their feelings toward the child and his blindness; fathers often express a sense of inadequacy in knowing how to function with the child.
5. The child who is blind seems to be more emotionally vulnerable than other children and therefore to suffer more keenly when parents tend to be compulsive in their treatment or unable to give their warmth to the child. Parents may not be able to unbend toward the child because of their own feelings toward blindness.
6. There has generally been a multiple-discipline approach to the child's problems. In many instances children have attended one or more school programs and have been known to several social and health agencies.

Few blind children in the total population have such gross abnormalities as to need custodial care. However, the symptomatic behavior of the children under discussion is not always irreversible and should not be regarded as a basis for institutionalization. Parents can be so overwhelmed with grief and fear that they can offer little in the way of the one-to-one relationship needed by the very young child.[11]

Some blind children have resembled in appearance and behavior the emotionally deprived babies studied by René Spitz.[3] Moreover, they have responded effectively to management and treatment based on an understanding of their functioning in relation to their sensory deficit. As Norris has reported, the parents' initial attitudes toward the child and the existence and use of the appropriate community resources available to meet his needs will determine in large measure the "opportunities for learning" which the child will enjoy as well as his subsequent development.[2]

Appropriate Services

Perhaps the first steps in enabling a blind child to enjoy and benefit from an educational program must be directed toward helping his parents, for it is in the home in early life where the child normally develops trust, confidence, and belief in himself as a person. Accordingly, programs for blind children emphasize social casework service for the parents in an effort to give them a better understanding of blindness, of their own feelings toward their blind child, and of his developmental needs in relation to his visual loss. A second major focus of a program for blind children may be on helping the child himself to a better understanding of himself as a person. In some instances the child may need psychotherapy or "play therapy," carried out by a skilled technician familiar with the effects of blindness. However, the expense and in some areas the inaccessibility of such skilled help may make such treatment prohibitive for many families.

For the younger child a carefully selected nursery school may be recommended where the child can learn about himself as he is learning to respond to teaching techniques. Many blind children who exhibit bizarre behavior have never experienced the kind of close, warm, or continuing and satisfying relationship with adults provided in many nursery schools.

Many persons who have worked with children with atypical behavior say that attention should be given to helping to build in the child a realization of personal worth rather than upon treating a particular symptom of emotional deprivation such as a lack of speech. However, speech therapy, per se, may be needed by some blind children who have articulatory problems or hearing defects.

Some of these blind children with behavior problems may have above average potentialities. Their keen sensitivity may be behind the severity of their reactions to the circumstances in which they have been growing. Such children may respond to learning experiences directed at broadening their knowledge of people, of the community, and of the world in which they are living without the great aid of sight.

Other children may be slower learners who require and respond to a slow approach with repetition and patience. But whether slow or bright the child needs some group experience and some individual help. The teacher, perhaps, must be part therapist—to know *when* to bring the child to a new experience—and part artist—to know *how* to provide this experience for him.

Many children upon reaching school age need an educational program provided on a residential basis, preferably in a location where the administrators may have available expert medical, social, and psychological services. Such a program allows the child to experience a change from the environment which may have been accentuating his problems, provides consistency of treatment, and permits opportunity for observation of his behavior by skilled professional persons on a continuum.

Every effort should be made to see that none of these blind children is overlooked, and that each receives the kind of individual attention that will permit and enable him to grow and develop to the maximum of his potentiality.

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[1] Bauman, Mary K.; Hayes, Samuel P.: A manual for the psychological examination of the adult blind. New York Psychological Corp., New York, 1951.

[2] Norris, Miriam; Spaulding, Patricia J.; Brodie, Fern H.: Blindness in children. University of Chicago Press, Chicago, 1957.

[3] Spitz, René: Childhood development phenomena; the influence of the mother-child relationship and its disturbances. *In* Mental health and infant development, vol. 1, Basic Books, New York, 1956.

[4] Jervis, Fred: A comparison of self-concepts of blind and sighted children. *In* Guidance programs for blind children. Perkins School for the Blind, Watertown, Mass., 1959.

[5] Hayes, Samuel P.: First regional conference on mental measurements of the blind. Perkins School for the Blind, Watertown, Mass., February 1952.

[6] Krause, Arlington C.: The effect of retrolental fibroplasia in children. *Archives of Ophthalmology,* April 1955.

[7] Patz, Arnall: Oxygen studies in retrolental fibroplasia. *American Journal of Ophthalmology,* September 1954.

[8] Gibbs, E. L.; Fois, A.; Gibbs, F. A.: The electroencephalogram in retrolental fibroplasia. *New England Journal of Medicine,* December 22, 1955.

[9] Parmelee, Arthur H.; Fiske, Claude E.: Wright, Rogers H.: The development of ten children with blindness as a result of retrolental fibroplasia. *A.M.A. Journal of Diseases of Children,* August 1959.

[10] Timberlake, W. R.: Neurological changes among children with retrolental fibroplasia. Twelfth annual meeting of the American Academy of Neurology. Miami, Fla., April 1960.

[11] Bowlby, J.: Maternal care and mental health. Monograph Series No. 2. World Health Organization, Geneva, 1952.

THE DENTAL PROBLEMS OF HANDICAPPED CHILDREN

DON CHALMERS LYONS, D.D.S.
Chief, Dental Staff, W. A. Foote Hospital, Jackson, Mich.

IT IS SAID we face the world with our face. Facial malformations and bad teeth, suffered by many handicapped persons because of poor oral habits and care, are a potent factor in personality maladjustment and withdrawal from normal social contacts. Employment agencies which try to place the handicapped in useful jobs are conscious of the fact that, while some crippling conditions are overlooked by employers, facial deformities are a tremendous handicap for the employee to overcome in his adjustment with other employees. Judges of juvenile courts have noted that young persons who cannot find social acceptance because of physical deformity of the face often turn to juvenile delinquency.[1]

Dental treatment for the handicapped child in many communities is an almost totally unsolved problem, and dental health programs for handicapped children are alarmingly backward.[2] While numerous social agencies, public and voluntary, provide training facilities for the handicapped, very few, except in some large cities, concern themselves with or allot funds for a complete dental program to maintain and restore the teeth and the tissues of the mouth.

The little that is done is usually on a limited volunteer basis by dentists, their local societies, some service clubs, and locally administered trust funds for welfare work. Dental programs sponsored by social agencies too often provide nothing more than emergency relief of pain by indiscriminate extraction of teeth.

Examinations of various groups of handicapped children throughout the country have disclosed the fact that they suffer from a great variety of untreated dental disturbances: incoordination of facial and masticating muscles; food impactions around and between the teeth; congenital defects of the teeth and tissues; spontaneous bruxism (grinding of the teeth); mouth breathing; alterations in the gingival blood supply; excessive caries; malocclusion; gingival changes due to drugs; abnormal tongue pressure effects; nutritional defects which affect the gums and teeth; inflammatory changes due to chronic abscesses; broken teeth, poorly calcified and discolored teeth; drifting of the teeth; crowding and other position abnormalities; cheek or lip biting; and many other defects. These have been aggravated by lack of understanding of the meaning of dental hygiene, lack of a routine program of teeth cleaning, absence of functional stimulus of the gum tissues.

The presence of these conditions in the handicapped child depends entirely upon the amount of routine care given the child. Studies have indicated that when the handicapped child is given proper dental care the percentages of abnormalities, and their DMF index (decayed, missing, filled teeth index) are similar to those for normal average children.[3 4 5 6]

These studies show that when average dental attention is not available to children with cerebral palsy, a large percentage of them become dental cripples by the time they reach their teens, losing as much as 20 percent of all their permanent teeth by the age of 12. That means that if the same rate of loss continues through their teens, the mouth is endentulous by the time the individual is twenty-one. In these children the muscles of mastication—of the throat and tongue—are abnormal and bruxism or teeth grinding is frequently present; moreover, such children are prone to falls. Therefore, many of them cannot wear or tolerate removable appliances or dentures. One study found evidence of bruxism in 80 percent of the cerebral-palsied children studied.[7] The bruxism causes ordinary fillings to break out easily and prevents construction of many types of dental restorations.

A high percentage of caries in anterior teeth is found in handicapped children, with many teeth showing hypoplasia, or defects in formation. Nearly all of these defects are accompanied by some degree of inflammation of the gum tissues which eventually leads to puffy bleeding gums and loosening of the teeth. Thick hypertrophic gum tissues are characteristically found in epileptic children who take dilantin regularly as an anticonvulsant. Broken and chipped anterior teeth are common among children who fall frequently because of epilepsy, cerebral palsy, or the effort to learn to use braces or crutches.

Oral Hygiene

Lack of good oral hygiene undoubtedly contributes to the high incidence of dental caries in many handicapped children, especially those with cerebral palsy. But this lack of oral hygiene cannot be laid simply to neglect. Even those who are able to dress and feed themselves are not able to acquire real skill in daily hygiene procedures until they have undergone a considerable amount of training. Ordinary tooth brushing technics are often impossible for them to master without the use of special brushes or specially constructed handles on the brushes. Mechanical tooth brushes are of value where arm motions are limited. Parents may try to do a good job of teeth cleaning for these children, but they also need special training.

Food intake may fulfill all requirements for proteins, carbohydrates, fats, minerals, vitamins, with normal caloric content, but if the food is soft, semiliquid, and sticky, food particles pack around the teeth, and it becomes cariogenic. This type of food is fed to many cerebral-palsied children because it is easiest for parent and child to manage. Training clinics for these children should give more attention to helping children learn how to use specially constructed utensils and to master technics of mastication so that they can attain a more fibrous, self-cleansing, dentally acceptable diet.

Children with neuromuscular difficulties are especially handicapped in their ability to masticate food for they have facial and masticatory muscles which do not respond normally. Often the resulting movements are involuntary and jerky. There may be semirigidity, or, on the other hand, a slackness in muscle tone. Since the shape of the dental ridge that holds the teeth is influenced to some extent by muscle use and function during the growth period, chewing methods, associated habits such as finger sucking and mouth breathing, tonicity of lips, size and activity of tongue, all exert a molding influence. As a result, variation in the dentofacial pattern is in direct ratio to the degree of physical handicap or deformity.

Many children with neuromuscular handicaps cannot chew because excessive extractions have resulted in drift of the remaining teeth. Open bite, or inability to articulate any anterior teeth, is common among such children. Their teeth may also be pushed out of position because of tongue habits, an extra large tongue, or overactivity of the tongue. If these conditions are not corrected insofar as possible during childhood and the teenage period, the mouth becomes "socially unacceptable" in adulthood.

Effective dental care primarily depends upon two things: (1) prevention of the development of dental caries, occlusal deformities, and oral diseases; (2) prompt early correction of defects, with adequate restorations or treatment as indicated. Preventive measures and training procedures can be effective if carried out in a continuing process by skilled individuals. However, trained personnel to form a team of dentists and dental auxiliary personnel such as hygienists are in short supply, and few are willing or able to carry out on a purely altruistic basis the continuous kind of program needed for each child. Social agencies should be made aware of the value of expending funds for adequate dental facilities and treatment.

Costs and Shortages

In comparison with many forms of medical treatment complete dental treatment is not expensive, though it often seems expensive when estimates are based on a single restoration rather than on total care. The Bureau of Dentistry, New York City Department of Health, has reported that, with administration included, it cost about $500,000 to give complete dental rehabilitation services to 2,662 children last year, or approximately $190 per child.[8]

Clinical facilities for this type of dental care are almost completely lacking in small communities and small community hospitals. This is in part due to the shortage of dentists in general. A report published in 1959 by the Public Health Service, U.S. Department of Health, Education, and Welfare, shows a continuing decline in the ratio of dentists to population, and warns that unless efforts are made immediately to correct it there will be only 50 dentists per 100,000 persons in 1975 compared with 57 in 1958 and 62 in 1940.[9] A group of consultants to the Surgeon General has recommended a billion-dollar program to expand and extend medical and dental schools.[10] They included in their recommendations the formation of 22 new dental schools.

In addition to an increase in the number of dentists, efforts are needed for increasing the ability of dentists to deal with handicapped children. Some moves are already being made in this direction, though more are needed. For example, the Office of Vocational Rehabilitation, U.S. Department of Health, Education, and Welfare, during the past 2 years has been sponsoring institutes for graduate dentists at various universities in the care of handicapped children and adults and persons with chronic disease. The New York University College of Dentistry is now offering two new graduate fellowships in dental care for the chronically ill and handicapped, with a master of science degree for a year's study.

An important part of building adequate care for handicapped children is developing a program for the child who cannot because of his physical defects give the dental-chair cooperation needed and also for the child with behavior difficulties due to neurological involvement or mental deficiency. In many of these cases the only way restorative or minor surgical work can be done is under a general anesthesia in a hospital or similar facility. Such time-consuming restorative work under these conditions requires special equipment and a special team of workers. The usual hospital operating room is not entirely suitable because it lacks dental units and the instruments needed in this kind of work, and because the necessity of room sterility requires certain procedures hampering dental work.

The homebound child also presents special difficulties. While the child might be transported to a hospital in an ambulance or through some other arrangement, this is not usually economically practical. Portable equipment which can be set up in the home is now under construction by several of the dental equipment firms. This type of equipment has been already demonstrated at several of the recent dental conventions and has met with surprising interest. When produced, it will solve a dental problem both for dentists who wish to use it in homes and for small community hospitals. Many such hospitals are financially unable to purchase a full permanent room of dental equipment which will be used only for the occasional patient and remain idle for several hours or days at a time.

There are estimated to be 750,000 cerebrally or neurologically damaged children and adults in the United States, one-third of whom are under 21.[11] If we add to these the thousands who are blind or have multiple sclerosis, muscular dystrophy, epilepsy, or rheumatic fever, or are slightly deficient mentally, and those afflicted with any of the many other handicapping conditions, the total is staggering, running into the millions.

The majority of these children can be trained to have a productive life by being taught to use what they have. Any complete rehabilitation program must include consideration of dental welfare. For a child to have to learn to live with his handicaps is enough of an emotional stress without having the additional burden of preventable and correctable disfiguring dental destruction, crooked teeth, pain and chronic debilitating infection from infected teeth.

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[1] University of Pennsylvania College of Dentistry, Philadelphia: Workshop on dentistry for the handicapped (discussion notes). September 1958.

[2] Album, M. M. (editor): Proceedings of the workshop on dentistry for the handicapped. University of Pennsylvania, Philadelphia, 1958. (Published with U.S. Department of Health, Education, and Welfare, National Society for Crippled Children and Adults, and Philadelphia Society for Crippled Children and Adults.)

[3] Galagan, D. J.: Development of dental health care programs for persons with chronic illness. *Journal of the American Dental Association,* December 1956.

[4] Lyons, D. C.: The influence of growth pattern on the maleruption of the maxillary cuspid teeth. *Journal of Pediatrics,* March 1955.

[5] ———: An evaluation of the effects of cerebral palsy on dentofacial development, especially occlusion of the teeth. *Journal of Pediatrics,* October 1956.

[6] ———: The dental problem of the spastic or the athetoid child. *American Journal of Orthodontics,* February 1951.

[7] Massler, M.: Perlstein, M A.: Neonatal and prenatal enamel hypoplasis in children with cerebral palsy. *In* Proceedings of the workshop on dentistry for the handicapped. M. M. Album, ed. University of Pennsylvania, Philadelphia, 1958.

[8] Simon, L. A.: Dental rehabilitation programs for children. *In* Principles and practice of dental care for patients with chronic disease and disability. New York University College of Dentistry, with U.S. Office of Vocational Rehabilitation, New York, 1959.

[9] U.S. Department of Health, Education, and Welfare, Public Health Service: Section 9, Health manpower source book series; physicians, dentists, and professional nurses. Public Health Service Publication No. 263, 1959.

[10] ———: Physicians for a growing America; report of the Surgeon General's consultant group on medical education. Public Health Service Publication No. 709, 1959.

[11] National Health Education Committee, New York, Facts on the major killing and crippling diseases in the United States today. 1957.

Mothers, fathers, and siblings are all a part of a family-oriented approach in . . .

A NURSERY SCHOOL FOR CEREBRAL PALSIED CHILDREN

LEE HEADLEY
Formerly Psychiatric Social Worker

HAZEL LELER
Formerly Nursery School Director

United Cerebral Palsy Association of San Mateo County, Calif.

THOSE WHO have worked with the handicapped know what a heavy emotional impact the birth and rearing of a handicapped child has upon a family. This impact is especially strong when the child has cerebral palsy, a condition which is frequently accompanied by visual, oral, and mental as well as motor handicaps.

Families with such children are often confused in their understanding of their child's condition and in their own feelings about the child. They are under pressures of anxiety, hostility, and feelings of guilt; are often drained financially by their efforts to secure the necessary medical care, therapy, education, and other special services; and drained physically by the enormous amounts of attention required by the child.

While special schools and classes are available in many places to the handicapped child of school age, for younger children, whose parents are often panic-stricken by their problems, help is meager and fragmentary.

In California, the United Cerebral Palsy Association of San Mateo County has developed a program designed to meet the needs of the young cerebral palsied child and to relieve his parents of some of the intolerable pressures upon them. The whole family—father, mother, cerebral palsied child, and his sisters and brothers—has been drawn into the efforts of a cooperative nursery school for very young cerebral palsied children.

The parents of the children who attend the nursery are required to participate in the school's program and attend parent education classes. Closely correlated with this educational and therapeutic program for the children are psychological services which provide sustained individual psychotherapy and group psychotherapy for the mothers. This combination of all services and the close working association of parents and staff gives the program its potential by involving the parents more deeply than can be done through the provision of occasional consultation or participation on a volunteer basis. The general feeling in this school is that the parents are proprietors and auxiliary staff.

The Beginnings

Five years ago, after consideration of the needs of the families with cerebral palsied children in the community, the association secured a psychiatric social worker as a first step toward meeting these needs. This worker, called a family counselor, found that her service was eagerly received by a number of families, but that others—especially those whose handicapped children were very young—first needed practical help in securing immediate treatment for their children and developing greater understanding of their children's potentials. While the local public school could, and often did, take children as young as 3 years of age into its nursery kindergarten, the school had to reject some such children as not sufficiently mature physically and emotionally for a public school program. Even 3 years

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of age is rather late for beginning much of the therapy cerebral palsied children need. If no service is offered before then the parents have to struggle alone to help the child in his early crucial years.

For some time cooperative or parent-participation nursery schools for normal children had been popular throughout California, and the association decided that such a program could be adapted to the needs of the cerebral palsied. In such a program very young children could receive therapy and social experiences in a relaxed setting. In participating in the program the parents could obtain a fuller understanding of the therapy, while some of their own needs could be met through the educational program of the nursery school and the individual and group psychotherapy offered by the family counselor.

The association considered some possible drawbacks to this program. These generally were expressed as: participating in the program would further concentrate the parent's attention upon the handicapped child who was already receiving more attention than the other children in the family; the presence and emotional attitudes of the parents might interfere with therapy; the parents could not be of much help in a treatment regime requiring a great deal of training and skill. Recognizing these possible drawbacks, the association nevertheless decided that some of them could be overcome or eliminated and that others would be negligible as compared with the values received.

Therefore, in 1956 the San Mateo Cerebral Palsy Nursery School was established, under the joint sponsorship of the United Cerebral Palsy Association of San Mateo County and the College of San Mateo. Fees paid by the parents were included in the financial support. The college was chiefly concerned with the parent education aspects and paid most of the teacher's salary for the first 3 years. The college then withdrew from the program and the association assumed the full support. The program has continued for 4 years and is still in operation.

The Program

At first cerebral palsied children from 18 months to 5 years of age were accepted, with physical and mental handicaps ranging from mild to extremely severe. Later, mothers were encouraged to bring even younger children so that they could receive help with feeding and other problems and the therapists could begin some of the treatment the children needed for their early development.

The nursery school usually has from 10 to 14 handicapped children enrolled. Most of them come to school three mornings a week, from 9 a.m. to 11:30 a.m., though a few of the younger children come only once a week. Mothers are required to participate one morning a week. They bring their children to school from homes scattered all over the county, sometimes forming car pools to do so.

The school staff consists of a nursery school director or teacher, an orthopedist as medical consultant, a physical therapist, an occupational therapist, and a speech therapist. These staff members have available to them constantly through weekly staff meetings and informal conferences the consultation of the psychiatric social worker and on occasion, when necessary, of a psychiatrist. Psychological testing is readily available from a number of sources. The psychiatric social worker also works with members of the larger community in efforts to establish needed resources.

The nursery school program is patterned very closely on the programs of most nursery schools, especially parent-participation schools. Regular nursery school activities and procedures are followed as far as possible with special emphasis upon the encouragement of self-help and on activities which fit in with the therapies needed by the individual child. Each child receives individual therapy sessions regularly each week with the therapists appropriate for his particular handicaps.

Each mother (in one family the father) has participated in the school program one morning a week. This means that each morning one third of the mothers are participating. The duties of the mothers are similar to those of mothers in other cooperative nursery schools in supervising and guiding the children's activities. In addition, they help feed, dress, and toilet the children, many of whom are very handicapped. Frequently the mothers help the therapists or observe the therapy to better understand the purposes and techniques. They occasionally make written observations on their own or other children.

The mothers also attend a parent education class. These evening sessions, conducted by the nursery school teacher, concentrate on child behavior and development in general as well as on subjects related to cerebral palsy, and on the nursery school program, its philosophies, therapies, and plans. Mothers discuss their problems concerning their normal as well as their handicapped children. Speakers and films are often used to focus discussion. Mothers are encouraged to ask "why", to feel free to disagree, and to take part in improvement of service, and generally are treated as important collaborators. During the first 3 years this class was held one evening a week. Following the withdrawal of the college's support, the association continued this class on a monthly basis. However, parents and staff agree that once a month is not sufficient to meet the parents' needs.

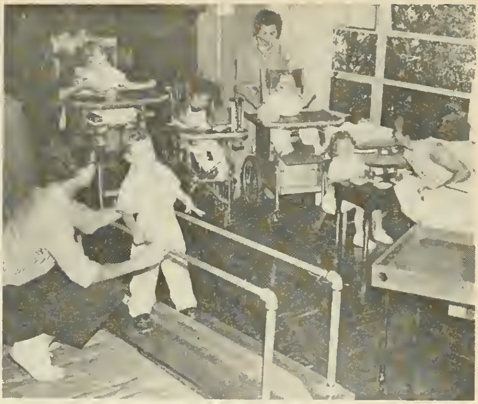
The fathers usually meet once a month for similar discussions. Fathers also occasionally observe the morning nursery school sessions. Some help with building equipment and repairs. Occasionally the school is conducted on a Saturday so that as many of the fathers as possible can observe the activities and therapy.

The physical, occupational, and speech therapists work with the children under the direction of the nursery school medical consultant, an orthopedist. A monthly clinic is held so that the progress of the children can be evaluated periodically and parents' questions answered. In the morning sessions, the therapists enlist the assistance of the mothers, instructing them in how to work with the children to achieve self-help in feeding, dressing, and toileting. They also teach the mothers some therapy techniques that can be applied at home and that can help them to understand better the purposes of the formal therapy sessions.

Normal Siblings

Some misconceptions held by parents were revealed early in this program. The mothers of handicapped children, particularly those who have no other children, frequently attribute all their child's problems and modes of behavior to the cerebral palsy, even behavior common among normal children. These misconceptions were corrected when normal children were also included in the program. Siblings of the handicapped children are now included if they are of nursery school age. Mothers can observe normal child behavior and, by comparing it with the behavior of the handicapped, can see more easily which behavior pattern in their child can be attributed largely to the handicap and which to the normal emotional and physical reactions of a child.

Admitting these normal siblings to the nursery school also has other values. The normal children stimulate the handicapped children to greater achievement and, by giving them an opportunity to associate with other than handicapped children, help them to receive a less warped view of the world. They also make it possible for a mother of both a normal and a handicapped child to bring them both with her to the nursery school and so to solve the problem of being away from the normal child on her day at the nursery.



A typical scene at the San Mateo Cerebral Palsy Nursery School where mothers and staff participate together in the therapeutic and educational activities for the children.

At first a few people objected to the inclusion of normal siblings in the program, contending that the normal children might tend to copy the handicapped children and thus become retarded in their own development. We have found a tendency to copy occurring only when the child first comes to the nursery school and then in only a minor way. If the handicapped child has been receiving a great deal of attention at home to the neglect of the normal child, the latter tends to become more dependent and to copy the handicapped child in some ways. However, as the normal child gains more attention and the parents receive a more objective and realistic view of the needs of both the handicapped child and his siblings within the family, this tendency disappears.

As the program progressed, it was obvious to both staff and parents that, valuable as it was, it had some limitations. These stemmed from the fact that the program was not providing for the expression of the deeper feelings of guilt, resentment, and frustration which so often interfere with parent-child relationships. Therefore the psychiatric social worker described the values of group psychotherapy to the mothers in one of their discussion sessions with the teacher. They expressed interest in this type of help, and all of the mothers voluntarily decided to participate in a 1-hour group therapy session once a week, with the psychiatric social worker as leader.

Nearly all of the mothers have participated in these sessions, which are held while the children are involved in nursery school activities. In them they discuss freely their deeper feelings and problems, and receive help and support both from each other and from the professional worker. Shortly after these sessions were underway, the professional worker, the nursery school staff, the medical consultant, and the parents themselves began to observe considerable improvement in the parents' attitudes toward their children. More parents were motivated to seek individual help from the psychiatric social worker.

Observable Results

One of the first results observed in the program was the almost immediate lessening of some of the mothers' tension. Many mothers remarked that they felt frighteningly alone with their problem until they entered the nursery school program, but that after they began participating in the program and became friends with the parents of other handicapped children, the sharing of their common problem made them feel less isolated. Mothers have also made it clear that, as in all cooperative nursery schools, the knowledge and experience they gain from supervising and observing a number of small children is of value to them as they work with their own children and that it also helps them feel more confident in continuing the self-help activities and therapy at home.

The nursery school's medical consultant has observed that the parents who have been in the program for about 2 years have come to a greater acceptance of medical evaluation and a more realistic view of their child's handicap and potential than other parents with similar problems. He has stated that the nursery school parents seem to have less resentment, misunderstanding, and destructive attitudes than other parents of handicapped children he has known. Similarly, teachers in the public school who by now have received some of the children once in the nursery school have said that their parents seem to have a more objective view of themselves and their children than parents in similar circumstances whose children have not attended the nursery school.

The nursery school staff as a whole has observed much growth on the part of both parents and children. The children have developed socially, emotionally, and physically. Moreover, they have probably suffered less emotional trauma from the various types of therapy they have undergone than they might have if their parents had not been so obviously involved in the nursery school program.

The staff has found that the presence and emotional attitudes of parents have not handicapped the therapists' work, although, of course, some individual problems have occurred. When parental attitudes have been disturbing, the parents have had an opportunity to work out the emotions behind them in the group psychotherapy or with the the psychiatric social worker or nursery school teacher. The therapists and nursery school teacher have been able to gear each mother's participation to her understanding and ability, and to help each parent appreciate the fact that some things are beyond her capacity.

Although some persons had feared that the mother's concentration on the handicapped child in the nursery school would cause her to neglect the other children in the family, this did not seem to happen. When mothers were able to relax more in relation to their handicapped child because of the diminishing of their sense of guilt, of their resentment, and of other tensions, they could devote more thought and attention to themselves and their other children. The parent education classes and group psychotherapy sessions helped them to understand the normal children and their problems as well as the handicapped and so to see their role as mothers in the entire family in better perspective. Many of them achieved a good balance between attention to the handicapped child and consideration of their other children, their husbands, and themselves Family life has thus been strengthened.

As Parents See It

Over the years no parent who has remained in the community has withdrawn from the program. except those whose children have been taken into the public school's special classes. The parents have all carried out their required participation willingly, and many of them have helped with additional projects.

After the program had been in operation for 2 years the staff sent a questionnaire to the 14 mothers to be answered anonymously. These were all returned promptly.

The questionnaire results indicated that the mothers spent an average of 8 hours a week each in the program—in transporting their children to the school, helping in the school activities, and attending the parent education and group psychotherapy sessions. To the question of whether this amount of time was compensated for by the values received, 12 of the 14 mothers replied that they felt it did.

In their returns the mothers indicated that the most useful results of their participation in all facets of the program were: (1) a clearer understanding of the child's handicap; (2) a perspective on the child in relationship to other children and to his own potential. Twelve mothers recommended the continuation of a parent participation program as against a shift to a program for children only.

The returns also showed that in the beginning the mothers had been uneasy about working with children who were severely handicapped physically or mentally. Thirteen of the 14 mothers said that they had been disturbed at the prospect of working with severely physically handicapped children; 11 were disturbed about working with the mentally handicapped. Eleven of the 14 mothers said that after a period of participation with these children they were no longer disturbed at all by working with physically or mentally handicapped children.

One mother wrote of her participation in the nursery school:

"I think it has helped my husband and me to become much more relaxed with our handicapped child. We couldn't have loved her any more than we already did, but we began to understand her so much better in her needs and wants. It also helped me in not babying her so much and waiting hand and foot on her. It has helped me to understand that she must do things for herself that she is capable of doing but take her a long time to do. Also it has helped her to become used to my not being with her all the time. She used to cry when she first started nursery school, but after a while she felt secure when I left her for the two and a half hours to shop and she had to stay there without me."

In regard to the family counseling and group psychotherapy the returns indicated that on the whole the mothers felt that it had helped them to understand themselves and their relationship to their children and to learn to handle themselves and their family situations more constructively; that it had relieved their anxiety about their child and increased their acceptance of his limitations and realization of his abilities.

The mothers reported that the group psychotherapy had helped them to recognize that others have similar feelings and family problems; to discuss their problems freely and receive help in regard to them; to formulate thoughts and feelings that they were only partly aware of previously; to assert in an accepting environment more of their own feelings and attitudes about their child, negative and positive; and to exchange pertinent experiences with other parents.

The others were asked, "If you were involved in setting up a nursery school for handicapped children would you recommend to such a group that the program include: individual family counseling? group psychotherapy?" Thirteen of the mothers answered "yes" in regard to individual counseling (one did not answer); and 14 answered "yes" to group therapy.

A Family Approach

What experience in the program can mean to a family may be illustrated with the A family in which the cerebral palsied child, a boy of 4, had been diagnosed as both mentally retarded and emotionally disturbed The mother came to the nursery school in a very questioning mood, inclined to disbelieve that her child was badly handicapped. She herself was a seriously withdrawn individual, unable to express herself, and very antisocial. After a long emotional struggle in which the other mothers and the psychotherapist participated, she came to realize the severity of her child's mental retardation.

Through the total family approach, which included staff talks with the father and his participation in fathers' meetings, as well as the mother's participation in the school activities and the psychotherapeutic sessions, she and her husband came to accept a fairly accurate appraisal of their child. The mother gained in her emotional stability and became more outgoing. She learned to cope with the very difficult behavior of a younger, normal child, who was included in the nursery school, and along with her husband was able to take appropriate steps for long-term care of their handicapped child after accepting the facts and their feelings about them.

Staff, parents, and interested observers of this program have come to believe that the key to helping such families as the A's has been the combination of services given to them and the awareness of the whole family's needs in all phases of the program. They also believe that this type of program would be applicable in work with children with other types of handicaps.

CONSULTATION WITH PARENTS OF DISTURBED CHILDREN

DAVID HALLOWITZ
Assistant Director

ALBERT V. CUTTER, M. D.
Medical Director

KATHARINE PITKIN
Psychiatric Social Worker

The Psychiatric Clinic, Buffalo, N.Y.

FOR THE PAST 8 YEARS the Psychiatric Clinic in Buffalo, N.Y., has been treating some emotionally disturbed children with considerable success, entirely through consultation with their parents. This process of parent consultation takes place in one to five interviews with mother and father together. It is used with parents who are judged, in the initial interview, to have the ability to get at the roots of their part in the child's difficulties during the course of these interviews and, with little or no additional help, to go on to resolve the relationship problems within their family. Although the clinic routinely recommends psychiatric evaluation of each child as a safeguard and as an instrument for furthering the work with the parents, for the latter purpose, this evaluation is found to be unnecessary in about half the cases.

At the present time 18 percent of the clinic's caseload falls in the parent consultation service classification. Without this service these cases would probably have been afforded full psychiatric treatment or have been on a long waiting list for it.

The essential features which differentiate parent consultation as used in the Psychiatric Clinic from other efforts to reach disturbed children through their parents [1, 2, 3, 4, 5] are:

1. It is effective for children of all ages.
2. The child's symptoms of disturbance are often multiple, of long duration, and bear a close resemblance to those of children requiring full diagnosis and direct psychiatric treatment.
3. The criteria for case selection and structure of the interviews are not applied in a preconceived manner, but are flexibly brought into play during the regular intake interview.
4. Mother and father (except when the mother is widowed or divorced) participate equally in a joint three-way interactive process with the worker.
5. The help given the parents is primarily in the realm of self-awareness and self-understanding.
6. Safeguards are rigorously instituted, and include followup procedures systematically applied over a period of several years.

Recently the clinic reviewed the 50 parent consultation cases which were active in 1954 and which were followed up regularly for from 2 to 5 years. Except for the stipulation that they be cases which were handled by senior staff members—to reduce as much as possible the variable of competence and skill—the cases were randomly selected. Twenty-eight—56 percent—were regarded as successful; 8, or 16 percent, partially successful, with residual problems; and 14, or 28 percent, failures. Further service in the form of full diagnosis and treatment was offered in the 14 cases of failure, was declined by 9, and accepted by 5.

A case was considered to be successful if the child's presenting problems had cleared up following the help given the parents and if he seemed to be adjusting well within the family, in school, and with other children. Conversely, a case failure was defined as one in which the parents were not really helped and the child's problems did not become resolved. We realize that a margin for error exists in the objectivity and reliability of the parental versions of the child's progress or lack of progress but this, we think, would be minute.

Based on a paper presented at the 1960 meeting of the National Conference on Social Welfare.

In reviewing these 50 cases we not only compared the characteristics of the successes and the failures but also the characteristics of the total group with the characteristics of children in the treatment caseload as described in a previous study of 246 of our clinic cases.[6] For the sake of simplicity, we have combined the 36 successful and partially successful cases in making the comparison with the 14 failures. Here are some of the findings:

Age of child; sex; ordinal position; age of parents; socio-economic and educational status: No significant differences in these factors existed between the parent consultation cases and the total clinic caseload; nor in the association of these factors with success and failure in the two groups.

Presenting problems: A wide variety of symptoms of emotional disturbance is contained in the 50 parent consultation cases. Each child's symptomatic picture was crudely designated either as having an acting-out quality or a quality of internalization. The largest proportion of these children, 54 percent—or a total of 27—were classified as "acting out," though among the failures as a group the reverse was true—55 percent were regarded as having tendencies toward internalization.

Symptomatic acting-out behavior included such behavior patterns in the child as extreme defiance and control of parents; temper tantrums; belligerence; aggressive and destructive outbursts toward parents, siblings, teachers, and classmates; willful refusal to go to school or do schoolwork; stealing and other forms of delinquent behavior; fire setting. Symptoms of internalization tendencies included: enuresis and soiling; masturbation; stuttering; functional headaches and stomach aches; withdrawal and apathy; fears, nightmares, sleeplessness; obsessive-compulsive traits. While we recognized that particular symptoms might relate to either tendency, we tried to assess them in relation to the child and the family situation as a whole.

Our purpose in this rather unscientific examination of symptomatic behavior was to find out whether or not the children of the parent consultation cases resembled those who needed full diagnosis and treatment. Symptomatically they did resemble the other children, for the percentage of acting-out children in the total caseload, 51 percent, was only slightly lower than in the parent consultation group. However, among the children of the parent consultation cases, symptoms suggesting neurosis or prepsychosis proved to be either signs of the very early stages of the condition or completely superficial and illusory, and tended to disappear in a relatively short period of time—a few weeks to a few months—while the child became better adjusted in every area. The conclusion that the children in parent consultation cases were not nearly so disturbed as the children in the treatment caseload was borne out by the psychiatric evaluations that have been carried out on the former during the past 2 years.

Prior duration of child's difficulties: Among the parent consultation cases the length of time a child had exhibited difficulties before the parents came to the clinic varied widely, ranging from 4 or 5 months to 8 or 9 years. But 37 percent of the successful cases had a prior-problem-duration of less than 2 years, compared with 25 percent of the failures.

The prior duration of the child's symptoms was generally shorter in the parent consultation cases than in the regular treatment cases. It was also shorter in the successful cases than in the unsuccessful ones, but not substantially so.

Parent problem areas: Here, the only comparison made was between the successful cases and the failures. The parental problems in the successful cases were markedly less complicated and severe than in the unsuccessful ones. The parents' problem in 92 percent of the successful cases existed solely in their relationship to the child. However, in 65 percent of the cases of failure the problem was complicated by marital disturbances or mental illness in one of the parents. An additional factor in the group of failures was a deeper disturbance in some of the children than was recognized in the initial interview.

Criteria for Selection

On the basis of these comparisons, it is possible to formulate criteria of a case suitable for parent consultation. These criteria cannot be applied inflexibly but only as working guides. Exceptions can be made.

1. Child: The child's symptoms, even though they may suggest the beginnings of a neurotic or prepsychotic process, are not yet deeply ingrained but are principally reactions to weakness, conflict, and breakdowns in the parent-child and parent-parent (re child) relationships. In fact, the child gives evidence of having substantial areas of inner strength.

The child's age and the prior duration of his symptoms are not determining factors in the choice of the parent consultation approach. The approach has proved effective with adolescents as well as with preschool children. It has also been effective in cases in which the child's symptoms have been present for several years. However, the younger the child and the shorter the duration of the symptoms, the better are the chances of a successful outcome.

2. ***Parents:*** The parents are in basically good emotional health as individuals, and their marital relationship is fairly sound. They genuinely wish to examine themselves and their part in the child's emotional difficulties. Moreover, they are capable of doing this securely and with a minimum of resistance and defensiveness. They are quick to gain insights, grasp concepts—on an emotional as well as an intellectual level—and to apply their new understanding with conviction.

Although the parents feel frustrated and angry with the child and themselves, on a deeper level they love him dearly.[7] The breakdowns are in the superstructure of intrafamilial relationships. The foundation is a good one upon which the relationships can be repaired or reconstructed.

The age of the parents and their socio-economic and educational level are not determining factors. However, the clinical impression is that younger parents (parents in their twenties and thirties) are more resilient and amenable to change than parents in their forties and fifties. Good intelligence—but not necessarily higher education and social position—is a favoring factor.

The Dynamics

Let us turn now to the dynamics of the parent consultation process. In the 90-minute joint intake interview with the parents the worker arrives at presumptive diagnostic impressions about the child through evaluation of his symptoms, the origins of their development, and the significant medical and developmental history. Through discussion, and direct observation of the parents and their interaction with each other, the worker also gains diagnostic impressions of the parent-child relationships, the parent-parent relationship, and the state of each parent's emotional health.

In about the middle of this session, the worker makes the hypothetical determination as to whether or not the family situation approximates the criteria we have described. Instead of the traditional detailed history-gathering and extensive discussion of parental feeling about seeking help, he focuses upon the parents' problems which might underlie the child's difficulties. He tries to help them realize that in spite of their problems with the child and angry feelings toward him, and perhaps toward each other, they are not "bad" parents but only lost in their parenting and have many good, healthy qualities on which to build. By thus reviving and reinforcing their own self-confidence, the worker helps the parents to achieve understanding on an emotional level of the ways in which they have contributed to the child's problems. The worker helps the parents to formulate plans of action themselves, but also gives specific directions and suggestions in a supportive manner.

Mr. and Mrs. S described Larry, age 11, as always having been rather quiet, introverted, a worry wart, and a perfectionist, but said they had not become alarmed about the boy until 8 or 9 months before they came to the clinic. They said the child's neatness seemed to be almost an obsession with him. He arranged shoes in his closet, smoothed out his clothes, made numerous minute adjustments of his music stand, straightened and lined up papers, closed all desk and bureau drawers carefully. They said that Larry had never been a disciplinary problem and had always been well liked, but now seemed to have reached a point where he had no friends and apparently no desire for any. They reported that Larry's teacher liked him, but that her patience had become exhausted with his puttering and slowness.

Larry's developmental and medical history was normal. The social worker had previously learned from the pediatrician[8] that no medical or organic problems were present, and from the school that the boy was of average intelligence and performed adequately prior to the intensification of his difficulties during the past year. In a brief discussion with the parents the worker also learned that their marital relationship and earlier family background seemed to be normal.

With these indications that a parent consultation process might be applicable, the social worker now began to focus upon the underlying problems in the parent-child relationships, and in the parents' relationship with each other as this affected Larry.

The social worker asked the parents what they thought might explain the child's symptoms. Mrs. S tentatively suggested that perhaps she and her husband had not been spending enough time with Larry. Mr. S added that he did not have a close relationship with the child. He said he had always found it difficult to get the boy to do things with him. He said, for example, that if he were washing the car, Larry would not come over to help, whereas Nancy, age 6, would eagerly do so. Mr. S recalled that when Larry was a young child, he would become discouraged when Larry would not come with him to take an automobile ride. When the worker encouraged him to talk about his feelings in regard to this, he said he used to feel angry and hurt but lately had come to feel badly about himself, thinking that he must have something missing which prevented him from having a closer relationship with his son. Smiling sheepishly, he went on to say that he used to feel jealous toward his wife because she was the one who had the close relationship with Larry. When the worker commented that he probably also felt resentment, he then admitted that he did, and turned to his wife, saying: "Whenever I am at the point when I want to talk with Larry about something, you are always right there ahead of me."

This kind of discussion led the parents to become aware of how Mrs. S unwittingly got in the way of her husband's efforts to reach Larry. She herself had been feeling resentful toward her husband for not having a closer relationship with Larry, thereby leaving the burden of this to her, and had thought that she had to make up for her husband's weakness in this respect. This was a revelation to Mr. S.

Explaining briefly a boy's early attachment to his mother as part of a normal oedipal struggle, the social worker commented on how difficult the father's pulling away from Larry must have made it for the child to come through this stage of his emotional growth. The worker pointed out that in spite of his apparent rejection of his father, Larry really has a great need for a relationship with him.

When the parents said that they have been trying very hard with Larry, recently by "pressing him" in regard to his school work, his music, going out to play with other children, the social worker asked them to consider how Larry must feel in reaction to these efforts on the part of the parents. They seemed to realize then that not being able to come up to their expectations may make the boy feel that they are disappointed in him and do not fully love him.

As Mr. and Mrs. S talked with Larry's sister, Nancy, their eyes glowed with pride. When the social worker pointed to the difference he observed in their feelings toward the two children, they recognized, that Nancy had "the inside track," but said they could not help feeling that way under the circumstances. The worker pointed out that this was only human.

Suggesting that because Larry is a worrisome problem to them, they perhaps tended to look only at the dark side of things in regard to him, the social worker asked whether the boy did not have some good qualities. Spontaneously and positively they talked about his considerateness, his musical talent, his intelligence, his likeability. The social worker emphasized that they must have a lot of good stuff in them as parents for Larry to have these good qualities.

In the course of this interview the parents began to think together about what they could be doing to improve their relationship with Larry. When the father told about a recent incident when Larry responded well to a suggestion that he help paint his room, the worker suggested that father and mother continue such efforts to get through to Larry by doing things with him and talking with him.

Before the interview terminated a plan was made for Larry to be brought to the clinic for psychiatric evaluation in a few months and for the worker to meet again with the parents at that time. However, as the time for the evaluation approached the parents canceled the plans for this and any further interviews. In an extensive telephone conversation Larry's mother reported that the boy's symptoms had greatly diminished, and credited this to application of the understanding she and her husband had obtained through the consultation they had received. Followup through periodic telephone conversations with Mr. and Mrs. S over the next 5 years indicated that the problem with the child had been completely resolved by the end of 6 months, and that this resolution was sustained.

Parental Problems

In this case illustration, several underlying parental problems were dealt with directly and dynamically: the distance and estrangement between father and son; the confusion and subconscious conflict between the parents which arose during the child's oedipal stage of development; the parents' resultant accumulated frustration and resentment; Larry's inability to satisfy the parents' high expectations; the parents' negative feelings toward Larry caused by his annoying symptoms and their more positive feelings toward their daughter.

In the other successful cases, similar parental problems and others were also effectively dealt with through direct and dynamic discussion.

An impairment in the father-son relationship was a major problem in eight of these cases. A factor frequently encountered, as in the S case, was the father's feeling of being rejected by his child and reacting with counterrejection and discouragement. One father was deeply disappointed in his son's lack of athletic physical makeup, inclination, and ability. Another father, according to his wife, acted toward his son as a supervisor acts in a business firm. Another father became aware that he was very authoritative and strict with his son because that is how he himself was reared.

Parents' weakness in discipline was a frequently occurring problem in the successful cases. The reasons for this varied from case to case, and getting at them was an important part of the interview. A father who felt that his wife was too strict with their child was excessively lenient and permissive to counterbalance this, and the ill feeling that grew up between the parents over this difference was transferred to the child. Another couple had been unable to have a child for 8 years and consequently after a daughter was finally born to them had become extremely anxious and overprotective toward her. Consequently, the little girl had developed such a demanding and controlling pattern of behavior that by the age of 4 she was the complete ruler of the household. A similar situation developed in a family with an adopted child. In another family overprotectiveness had developed after the child had had a serious accident and almost lost his life.

Another father and mother were concerned about the effeminate tendencies in their 9-year-old son, manifested by the boy's associating only with girls. The mother and the worker together helped the father bring out his worry over the possibility that perhaps he himself had an effeminate streak and that his son was taking after him. As he did so his wife helped him to see clearly the unrealities in his perception of himself. In another case a widowed mother feared that too close a relationship with her son would result in excessive feminine identification and consequent damage to his psycho-sexual development, and as a result she went to the other extreme of not showing him any affection. A divorced mother came to the sudden realization in the interview that she had feelings of hatred toward her son because he looked so much like his father.

In the cases that were unsuccessful, there was similar dynamic content in the initial interviews, which misled the worker into thinking that positive results could be achieved through the parent consultation approach. He was disappointed to find as time went on either that temporary or sporadic specific improvement was followed by complete return of the presenting problems; or that no improvement whatever occurred. The basic trouble lay in the incorrect evaluation of the parents and child.

For example, in one of the cases of failure, the ups and downs with respect to the child's presenting problems continued for about one year—during which there were intermittent sessions with the parents—until the social worker finally realized that there was a deep and chronic marital conflict and that the mother herself was sufficiently disturbed to require intensive psychiatric treatment. A review of the record indicated rather clearly that the worker should have been able to arrive at more accurate presumptive diagnoses of the family and of the mother early in the contact and that a treatment plan for child and parents, with special attention to the mother's psychopathology, should have been instituted. Such cases have taught us that when we do not see progress within a few months to look for deeper disturbance in the marital relationship, the individual parent, or the child.

Psychiatric Evaluations

Our failure cases point to the paramount importance of instituting effective safeguards in undertaking a program of parent consultation of this type. Psychiatric evaluation of the child as an integral part of the parent consultation process establishes the nature and degree of the child's disturbance. A finding that the disturbance is of a reactive nature adds substantially to the social worker's feeling of security in pursuing the parent consultation approach; and it is also reassuring to the parents.

The fact that the social worker sees the parents together during the child's two appointments for psychiatric evaluation provides him with an opportunity to extend and deepen his diagnostic understanding of them as individuals and of their relationship with each other. It also gives him additional opportunity to test out the parents' ability to act on the understandings they initially gained.

The process is carried forward still another step when the psychiatrist and social worker meet together with both parents in the summation interview. This direct contact of psychiatrist with the parents provides a check on the social worker's initial evaluation of the parents. Even though half the parents in the parent consultation group do not regard the psychiatric evaluation as necessary, the availability of the evaluation is a safeguard, and making use of it is strongly recommended to parents who falter in making progress with their child. Conferences between the worker and the psychiatrist who evaluates the child, supervision, and consultation are also vital safeguards.

Additional interviews beyond the summation interviews are scheduled when necessary. When the parents feel they can continue to make progress without further help, the social worker takes responsibility for keeping in touch with their progress regularly, mostly through telephone interviews.

There are, of course, weaknesses in this followup plan: a parent may try to cover up adverse developments as a self-protective measure or out of a need to please the worker; he might at the time of the telephone call be in a generally bad mood or be momentarily upset by happenings with the youngster, and so make statements that are more negative than the situation warrants; a telephone interview does not provide the interviewer with an opportunity to see the expressions and gestures that give clues to parental feelings. We believe, however, that much can be learned in the telephone interview when there has been a prior working relationship which immediately encourages openness and frankness on the telephone. The worker does not close the conversation if the parent says "everything is fine," but checks into specific aspects of the child's and the parents' interrelated problems.

The telephone interview calls for open-mindedness and objectivity on the part of the social worker which in turn intangibly encourages open-mindedness and objectivity in the parent. If there is an attitude of wishful thinking on the part of the worker this may result in the parent telling him only that which he would like to hear. Because we realize that at best the telephone interviews are only good indicators, parents are invited to come in for regular interviews when the worker has the feeling that this should be done.

The parent consultation process requires a social worker who has had enough experience with parents and children to be able to make presumptive diagnoses of the child and family; has been convinced by experience that certain kinds of parents can be reached relatively quickly and profoundly; who is creative, flexible, and able to think rapidly; and who has a considerable amount of professional security and maturity. Yet the safeguards of supervision, staff consultation, and psychiatric evaluation make it possible for less experienced staff members to learn this complex and difficult process.

We believe that with the effective application of the criteria enumerated in this article and the effective implementation of the safeguards mentioned, parent consultation has a place as one of the several closely connected and interrelated approaches to family treatment.

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[1] McLure, Dorothy; Schreier, Harvey: Preventive counseling with parents of young children. *Social Work*, April 1956.

[2] Wolfe, Bee: Some aspects of psychotherapy in counseling service to parents of young children. *Mental Hygiene*, July 1954.

[3] Schwartz, Anne C.: Family casework in behalf of children. *Social Casework*, November 1959.

[4] Alpern, Evelyn: Short clinical services for children in a child guidance clinic. *American Journal of Orthopsychiatry*, April 1956.

[5] Taft, Jessie (ed.): Family casework and counseling—a family approach. University of Pennsylvania Press, Philadelphia, 1948.

[6] Roach, Jack; Gersslin, Orville; Hunt, Raymond G.: Some social-psychological characteristics of a child guidance clinic patient population. *Journal of Consulting Psychology*, July 1958.

[7] Hallowitz, David; Stulberg, Burton: The vicious cycle in parent child relationship breakdown. *Social Casework*, May 1959.

[8] Hallowitz, David; Cutter, Albert V.: Pre-intake phase; the beginning of the intake process. *Mental Hygiene*, January 1959.

The overriding reason for doing everything we can to help a child to make the most of whatever potential he has is neither political, social, nor economic. I submit that the fundamental reason is moral. . . . In classrooms, on playgrounds, in social agencies, in reform schools, wherever children are met and served, the most telling test that can be applied to every relationship and program is to ask whether each child is given the respect and acceptance due a human personality.

John H. Fischer, Dean, Teachers College, Columbia University, to the 1960 White House Conference on Children and Youth.

FOSTER CARE LICENSING IN PUBLIC WELFARE

NORRIS E. CLASS
Professor, School of Social Work, University of Southern California, Los Angeles

GERTRUDE BINDER
Director, Bureau of Adult Institutions, New York State Department of Social Welfare, Albany

IMPORTANT CHANGES are taking place today in respect to the licensing of foster-care arrangements for children.

Foster child-care licensing, the oldest of State welfare departments' responsibilities, varies somewhat from State to State but in general it covers children who live away from home in foster homes, in institutions, or in day-care arrangements. In most States child-placing agencies and adoption agencies are brought within the foster child-care licensing law or are covered in closely related statutes. Whatever the specifics, the purpose of the licensing responsibility is to set up rules which those who wish to engage in foster-care activities must observe, so that users of the services will be assured of at least a minimum of protection against risks they may not be in a position as individuals to evaluate or deal with effectively.[1] Whether the legislation specifies the requirements that those who wish to engage in foster care must observe or whether the department formulates the standard, the standards have the force of law, since the legislature has invested welfare departments with legal authority to act for the protection of children.

Although in the beginning foster-care licensing was not extremely demanding of time and attention, today this responsibility is taking on increasing administrative significance in public welfare departments. A variety of reasons account for this. First is the expanding magnitude of the task, due particularly to the ever-growing demand for day-care services. Also new areas of protection are being proposed or actually brought under the foster child-care licensing statute. This includes such "peripheral" foster-care services as summer camps—even babysitting!

A second reason for the increased administrative concern with foster-care licensing in public welfare departments is the shift in the kind of applications these agencies are receiving. In the days when the public welfare department had the licensing responsibility only for children's institutions, child-placing agencies, and foster-family homes, applicants were pretty consistently free of profit motives. The great majority of institutions and child-placing agencies were sponsored by religious or benevolent organizations. While some of these organizations were very possessive of their right to care for children in their own way and challenged the licensing standards they were required to meet, they were altruistically oriented and joined with the licensing agency in having the welfare of children as a basic and ultimate concern.

This traditionally was also the orientation in foster-family homes for children. While the foster parents were usually planning to charge board and perhaps even regarded the board payments as added income, they were in general chiefly motivated by their interest in children. What little they received as compensation was quite extraneous to their basic "liking of kids."

The situation has now changed somewhat, especially as a result of marked increase in demands for day care services for children. Although the application to run a day care program may be sponsored by a religious, benevolent, philanthropic, or a "neighborhood co-op," the chances are that it will not be. In contrast to most applicants in the past the applicant today is less likely to be "completely" altruistically motivated. Of course, a lack of altruism as the predominant motive is not necessarily accompanied by disinterest in children, a lack of sensitivity, or irresponsible performance. However, the motivation of many license seekers today consists predominantly of the hope for a financial gain, although the amount may be very modest. Moreover, the operation may require a considerable investment of money, a fact which is conducive to the development of a "vested interest."

Thus from the viewpoint of many applicants child care is a business. This situation tends to present a "difference" to the professional social worker who has not traditionally thought of child care in this light. Administratively there needs to be an accommodation to this new "fact of life". Experience would indicate, however, that it can be dealt with positively as well as negatively. When the licensing worker has a sound knowledge of good practice in child care (and can communicate it) the licensees are prone to seek consultative service to protect either their financial or ego investment or both.

Operators' Associations

A third factor in the increasing administrative concern over licensing in public welfare departments is corollary to the change in type of clientele. This is the growth of organizations representing the regulated groups. In many instances the applicant for a license or license renewal who is challenging an order by the licensing agency or facing a possible revocation action, is an actual or potential member of an association of "operators," which has as one of its primary aims protection of group interests.

To be sure, organizations of institutions and of agencies existed in the early days of licensing. In a few instances even foster parents were organized. There is a difference, however, between associations of nonprofit agencies and associations of operators interested in profit as well as in children. Certainly the necessity of dealing with this newer kind of organized group adds a factor to be reckoned with to the job of administering welfare licensing responsibilities. However, from a community organization viewpoint these associations also present some real possibilities for maintaining or raising standards of child care. The associations assisted, perhaps, by the licensing worker may (and do) arrive at standards on their own that are equal to or above those required by the State. Thus enforcement, in a sense, becomes "internalized" and releases the energies of the licensing staff for other more constructive activity.

Another aspect of the licensing responsibility which is consuming administrative attention in public welfare departments is its tendency to make for expanded interdepartmental relationships. Licensing an institution for children (or for the elderly or the mentally ill) may involve setting standards and passing judgments on matters outside the competence or the province of staff in public welfare departments. The protection of dependent persons requiring care away from their homes requires the formulation and implementation of standards in areas so varied that they call for specialized knowledge from many different fields—public health, fire protection, safety, nutrition, recreation, and even personnel administration. The need for cooperative and coordinative activity is recognized in some licensing laws by stipulations that there must be prior approval by some other department such as the fire marshal or board of health.

This means that if the public welfare department is to do a thorough job of protection it must effect a network of cooperative working relationships with a large number of public departments and several levels of government. The job of securing and maintaining these relationships takes considerable staff time and energy. This costs money and must be dealt with in welfare department budgets. At the same time, the service furnished by the other public agencies also costs money and presents them with budget problems.

Thus licensing requires the finest kind of interdepartmental planning. In fact, once a public welfare department takes on a licensing responsibility it cannot live unto itself. Any previous lip service to the value and feasibility of public administrative coordination must give way to genuine working understandings if the purpose of licensing is to be truly realized.

How these working understandings are achieved will be dependent in part upon specific provisions of the licensing law and in part upon previous patterns of cooperative action. For example, Washington is one of the States where the law vests the State department of public assistance with the licensing authority over child-care agencies and institutions but requires prior approval of each facility by the State fire marshal and the State department of health. To integrate the work, the department of public assistance, as the licensing authority, established a committee with a representative from each of the three. The committee's work resulted in a strengthening of relations among the State departments and the licensed agencies.[2] In California at staff development meetings of licensing personnel, the holding of panel sessions made up of representatives of various departmental personnel connected with licensing has proved to be very helpful.

The Licensing Function

If these growing demands on the licensing responsibility are to be met effectively, a greater understanding is needed both within and outside the public welfare department of the similarities and differences between the licensing function and the department's more generally familiar functions of providing financial assistance to relieve economic need, or individualized services to persons with other problems.

The carrying out of the foster care licensing responsibility by the public welfare staff is in many ways similar to what is involved in the implementation of assistance or service programs. All must be performed within legal limits and according to rather well-defined administrative procedures.[3,4] The agency activity is usually initiated by the applicant requesting something—be it assistance, service, or a license—although the circumstances bringing about the request are quite different. In each instance, an investigation is made and a considerable amount of decision-making takes place before the request is granted or refused.

Licensing, however, is distinguished by two differential aspects: (1) the attitude of the applicant seeking a license; and (2) the impersonality of the service because of the remoteness of the individuals being protected.

Attitude of Applicant. The assistance or service applicant requests some tangible form of help—something given to him, or performed for him. On the other hand, the applicant for a license sees his request as asking for permission to do something on his own which he usually regards as his right to do. Because of our culture, there is a vast difference in the thinking and emotions that these respective attitudes engender. From the viewpoint of public welfare administration, the difference may have implications for operational skills and practice. This is especially true in respect to the way the applicant's conscious and unconscious behavior (in contrast to verbalizations) are dealt with in making decisions on whether or not to issue a license.

Impersonality of Service. In assistance or service the person in need is right at hand and the social worker effects a working relationship with him in an effort to be specifically helpful. In welfare licensing, the persons in need are to be served by the applicant for the license, who is required to meet certain standards to protect them. Generally speaking, this protection is *a matter of futurity and nonspecificity.* The worker must decide whether the service will meet the needs of children generally, not of a specific child!

Thus the departmental worker's decision-making must in a final sense be normative, that is, sociologically rather than psychologically oriented. In fact, the agency focus on the normative is sometimes actually expressed in law. For example, the Delaware boarding home licensing law contains this clause ". . . that individual homes meet the physical, social, moral, mental, educational, and religious needs of the average child." Many complications are introduced into personnel administration by this aspect of licensing.

As already indicated, social workers, by professional tradition, are interested in specificities. They tend to be concerned about helping a *given* child or family with a *given* problem. In licensing, this interest in specificities must give way, in a sense, to prediction. The licensing worker must find satisfaction in predicting that a certain type of child with certain general needs at some *future* date will receive satisfactory care in this foster care situation. Although it may be granted that this type of predicting is an important and valuable vocational activity, it is not what social workers tend to do routinely.

Personnel Qualifications

This last raises the question of personnel qualifications for licensing, a subject which has been treated more fully elsewhere[5] than it can be in the short space allotted here. Two personnel qualifications are absolutely necessary. The first is that the licensing worker must be comfortable and skillful in working with policy, both its application and its development. The clinically oriented social worker, or the person who measures his achievement by the extent to which he can exercise highly individual judgments, may find little satisfaction in applying licensing standards. In fact such a worker may become a source of confusion to the regulated group and a liability to the licensing agency. This does not rule out the importance of the licensing worker's understanding those with whom he deals, respecting their feelings and protecting their rights. It does mean, however, that his primary focus must be on seeing that licenses are issued promptly to people who meet standards, and that no one receives a license or continues to operate a facility subject to regulation unless he does meet the licensing requirements.

A second essential personnel qualification is the ability to be comfortable with the authoritative nature of the licensing responsibility, even to the point of taking court action. No matter how carefully licensing policies and practices are formulated, nor how skillfully the personnel applies them, there will be situations in which individuals or institutions will fail to conform. Willingness to invoke authority is essential to enforcement. It may also contribute to sound administration generally. A test of a standard—a requirement—in a fair hearing or court can play an important part in keeping licensing practice close to what public opinion will support. Licensing workers have not always made full use of this resource, looking at an adverse decision as an "ego" defeat. Actually a ruling, especially one by the court, regardless of which side wins, provides the department with an authoritative guide to future administrative actions and decisionmaking.

No program however desirable or beneficial administers itself. Only through full recognition of its values and also of its limitations will licensing make the contribution it is seemingly capable of making to the care and protection of children who must live away from their own homes. Such a protective program takes on added importance when there is marked social mobility and family disorganization as there is today.

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[1] Ferguson, Dwight: Maryland evaluates licensing of agencies and institutions. *Public Welfare*, October 1946.

[2] Emerson, Lola B.: Teamwork in licensing children's agencies. *Children*, July–August 1956.

[3] Binder, Gertrude; Class, Norris E.: The regulatory responsibility in public welfare; the nature of welfare licensing laws. *Social Casework*, November 1957.

[4] ————: The regulatory responsibility in public welfare; regulatory standards for welfare services. *Social Casework*, May 1958.

[5] ————: The regulatory responsibility in public welfare; maintenance of regulatory standards for welfare services. *Social Casework*, June 1958.

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

CHILDREN OF CHANGE. 30 minutes; sound; black and white; rent or purchase.

Shown first at the National Conference on Day Care for Children, this film illustrates how children of employed mothers can be cared for in a protected environment during the mothers' working day—how the children receive not only physical care, but also emotional support and guidance. Portrays foster-family day-care homes as well as day care centers.

Audience: Community planning groups; parent-teacher associations; nursery-school training classes.

Produced by: The Mental Health Film Board, for the Pennsylvania State Department of Welfare and the Children's Bureau.

Distributed by: The Mental Health Film Board, 166 East 38th Street, New York 16, N.Y.

MY OWN YARD TO PLAY IN. 7 minutes; sound; black and white; purchase.

Illustrates children's ingenuity and versatility in finding their own play materials and organizing their own creative play.

Audience: Classes or other groups studying child development.

Produced and distributed by: Edward Harrison, 1501 Broadway, New York 36, N.Y.

TO KEEP THEM WELL. 16½ minutes; sound; color; purchase.

Made for the National Health Council, this film stresses the importance of periodic medical examinations of well children and the importance of close communication between school and home in the health supervision of children.

Audience: Parent-teacher associations.

Produced and distributed by: Sam Orleans & Associates, 211 West Cumberland Avenue, Knoxville, Tenn.

GOING TO THE HOSPITAL WITH MOTHER. 25 minutes; sound; black and white; purchase or rent.

Demonstrates how a mother's being with her child in the hospital gives the child a sense of security and minimizes the injurious effects of the experience.

Audience: Medical and nursing students; parents; professional workers, especially those with pediatric backgrounds; hospital administrators.

Produced by: James Robertson in cooperation with staff of Amersham General Hospital, near London, England, and with patients and their parents, 1958.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N.Y.

BOOK NOTES

PHYSICAL DISABILITY—A PSYCHOLOGICAL APPROACH. Beatrice A. Wright. Harper & Bros., New York. 1960. 408 pp. $6.

Holding that the psychological aspects of disability may be more handicapping than the physical aspects, the author of this book, who is a psychologist associated with the University of Kansas, explores some social-psychological conditions in both adults and children which hinder or facilitate adjustment of the disabled. She offers rehabilitation workers guideposts toward building a good relationship with the parents of a disabled child; examines the problems of such parents, such as overprotecting the child or being too severe with him in an effort to train for independence; and discusses in detail ways of motivating disabled children to help in their own rehabilitation.

In a chapter on the adolescent the author notes that in adolescence the concept of self undergoes important changes, that physique plays an important part in the changing concept, that the adolescent's psychological state overlaps that of both childhood and adulthood, and that the adolescent boy or girl with a disability has to cope not only with the disability but with this transitional status.

THE PSYCHOLOGY OF CRIME. David Abrahamsen. Columbia University Press, New York. 1960. 358 pp. $6.

"Since criminal behavior begins basically in childhood or adolescence as an emotional and social adjustment, the elimination of crime depends principally upon the eradication of juvenile delinquency and its causes," says the author of this book, a psychiatrist. Emphasizing that no single element causes crime, he maintains that "definite biological, psychological, and sociological factors intermingle in the causal process," and points to four basic causes of delinquency: (1) abnormal family relations, (2) social disorganization, (3) individual mental and emotional illness, and (4) organic brain or endrocrinological conditions.

In the early development of a child, the author says, rebelliousness, fearfulness, and hostility are natural, but when these feelings in combination continue for a long time they become symptoms of emotional disturbance, which may lead to antisocial or criminal behavior. He suggests that no definite early signs of potential delinquency are at present recognizable, with one exception, habitual truancy—not an occasional day or two of hooky playing a year, but persistent absence from school without a legitimate excuse. This exception he derives from an examination of records of adult offenders, showing childhood truancy as the most common phenomenon among them.

DETENTION PRACTICE; significant developments in the detention of children and youth. Sherwood Norman. National Probation and Parole Association (now the National Council on Delinquency and Crime), New York. 1960. 221 pp. $2.50.

The extent to which some specific standards for detention care of children awaiting court action have been attained or surpassed by a number of institutions is described in this book, a companion piece to the 1958 "Standards and Guides for the Detention of Children and Youth," issued by the same organization. (See CHILDREN, September–October 1958, p. 191.) The inventory of practices in detention facilities was taken through a 2-year survey in more than 50 jurisdictions in many parts of the United States, financed by a grant from the Field Foundation. Twenty-three detention facilities are described in detail.

The author, who is director of detention services for the Council, points out that the objectives of good detention care call for special court procedures to control admission and length of stay; State standards and consultation service; specially designed fireproof buildings; a sufficient number of carefully selected staff under professional direction; an adequate budget; and regional arrangements, stimulated by the State, to enable small counties to have a place other than the county jail for holding children. He also stresses the disadvantages of detaining the child in any kind of facility when secure custody is not essential: high cost; encouraging the child to identify with other delinquents; discouragement of the probation officer from helping parents face their responsibility for the child.

SPECIAL EDUCATION OF PHYSICALLY HANDICAPPED CHILDREN IN WESTERN EUROPE. Wallace W. Taylor and Isabelle Wagner Taylor. International Society for the Welfare of Cripples (now the International Society for the Rehabilitation of the Disabled), 701 First Avenue, New York 17. 1960. 497 pp. $3.50.

The authors of this book visited 21 countries in Western Europe during a 10-month period and here report on those countries' educational services for the blind, the deaf, the crippled, the cerebral palsied, and other physically handicapped children. The book includes information concerning each country on the historical background of the services, legal and other definitions of various handicapping conditions, the incidence and prevalence of certain conditions, services provided under public and under private auspices and how they are organized and administered, and the training and licensing requirements for teachers of different types of handicapped children.

In a general survey of the information collected, the authors report that all the 21 countries have passed through similar stages in developing special education for the physically handicapped: (1) belief in the desirability of compulsory education for all; (2) recognition of the desirability of extending educational advantages to the handicapped; (3) parallel development of educational and health services; and (4) a trend for local, provincial, or national governments to accept more responsibility for services.

The report calls attention to the need for more specific information about financing special-education services, such as the per-pupil costs of education for various categories of handicapped children and the formulas for sharing costs among the localities, provinces, and national government.

HERE AND THERE

Conference on Day Care

More than 400 persons from all parts of the country met in Washington for 2 days in mid-November for a National Conference on Day Care for Children, sponsored jointly by the Children's Bureau, U.S. Department of Health, Education, and Welfare and the Women's Bureau, U.S. Department of Labor. They came from health, welfare, and educational, and labor organizations concerned with children's needs for day care.

At the opening session a panel of four speakers presented some of the facts of the socio-economic scene which have created an urgent need for increased day care services for children. Ewan Clague, Commissioner of Labor Statistics, predicted that by 1970 half of all the women in the population between the ages of 35 and 55 would probably be in the labor force, thus increasing the problem of the care of children of working mothers. Speaking of barriers to good day care services today, Mrs. Randolph Guggenheimer, president of the National Committee on Day Care, included "the tendency of those who are closest to it to apologize for it." She pointed out that the "wishful thinking" of persons who hope that by failing to supply good care they will induce mothers to remain at home only results in a staggering number of children being left unsupervised.

Anthropologist Ethel J. Alpenfels of New York University called for a new look at the American culture to determine what values should remain and urged persons responsible for day care services to see that they help children not only to learn, but also to think. Joseph H. Reid, executive director of the Child Welfare League of America, also called for a reexamination of current values, both general and professional, in an effort to understand why mothers go to work and what is impeding the provision of adequate day care services for their children.

A major portion of time was devoted to 12 discussion groups which met for an afternoon and a morning to consider such questions as the essential elements in a good day care program, the varieties of services to meet special needs, the promotion of adequate standards, community responsibility, and financing. One point repeatedly raised was a call for Federal participation and leadership in efforts to meet the country's day care needs.

This point was also stressed at the final session by the Secretary of Health, Education, and Welfare, Arthur S. Flemming. He maintained that the Federal Government had an obligation to help people agree on day care goals and on what is a fair share of responsibility between Federal, State, and local governments and voluntary agencies in meeting these goals; and to stimulate research and training projects in the area of day care. At this session Alice K. Leopold, assistant to the Secretary of Labor, stressed the manpower needs of the Nation and the contribution that high quality day care services can make in giving young children the groundwork for later education attainments.

In closing the conference, Katherine B. Oettinger, Chief of the Children's Bureau, congratulated the conferees for exploding a series of myths—that the provision of day care causes women to work, that day care services and baby parking are synonymous, that we now understand the best way to meet the needs of children whose mothers are away from home. She called day care a preventive service which must be provided even while methods are sought to improve it.

Among the material presented to the conferees prior to the conference were four new publications, which are listed in the Goverment-publications section of this issue of CHILDREN (see inside back cover): "Food for Groups of Young Children Cared for During the Day"; "Day Care Services"; "Children of Working Mothers"; and "Day Care of Children under 12—a report of the resources of national organizations."

A feature of the conference was the premiere of a documentary film, "Children of Change," showing a community program of day care for children. (See page 31.)

A major article reporting on the highlights of the conference discussion groups, by Gertrude Hoffman, Children's Bureau specialist on day care and homemaker services, will appear in the March–April 1961 issue of CHILDREN. The official report will be published separately later.

State Legislation

A number of studies of State provisions affecting children were ordered by State legislatures during the 1960 legislative sessions, including: *California*, programs for physically handicapped children; *Kentucky*, feasibility of establishing a home for illegitimate children; *Maryland*, illegitimacy among recipients of aid to dependent children; *Michigan*, State provisions for mentally ill, mentally retarded, emotionally disturbed, and "crippled and afflicted" children; juvenile problems and related factors such as work camps, detention centers, employment laws and regulations concerning minors, and the need for a juvenile study center or youth commission; and public welfare programs, including foster care and aid to dependent children; *West Virginia*, adoption laws.

Among other 1960 State legislative actions affecting children were the following:

In *New York* the legislature created a division of youth in the State executive department to replace the State youth commission and to reconstitute the latter as an advisory council. The new division was made responsible for a broad program on juvenile delinquency, to include provision of work camps for juvenile and other young offenders, and similar facilities to which potentially delinquent juveniles may go voluntarily. Legislation was also enacted bringing the State into the Interstate Placement of Youth Compact affecting adoptions. The effective date of the Youth Court Act, passed in 1956 (see CHILDREN, July–August 1956), was postponed for the third time. The new date is April 1, 1962.

In *Kentucky* a provision requiring court commitment for State crippled children's services was repealed. The name of the State crippled children's agency was changed from the Crippled Children Commission to the Commission for Handicapped Children. A division of mental retardation was established in the department of welfare.

The legislature also raised the minimum age for marriage from 16 to 18 for males, and from 14 to 16 for females.

In the *Virgin Islands* the legislature authorized the department of social welfare to establish a center for detention of children under 18 charged with an offense that would be a felony if committed by an older person.

The legislature also raised the amount of fees for payment for foster family care of children, setting a minimum of $40 per month per child. The fees are to cover as nearly as possible the per capita cost of care, based on the need of the individual child.

For Migrants

Specialists in welfare, agriculture, labor, transportation, education, and health met in Washington for 3 days in mid-November for a National Study Conference on the Church and Migratory Farm Labor.

Held under the auspices of the Migrant Ministry of the National Council of the Churches of Christ in the U.S.A., the conference included representatives of Catholic as well as Protestant Churches, Federal and State governments, voluntary health and welfare organizations, growers, and the migrants themselves.

The result was a "10-year plan" calling for greater effort by the churches to end deplorable working and living conditions among migrant farm workers and their families; Federal aid for the education of migrant children, for rest stops, and for loans to growers to build low-cost housing; and access for migrants to local health, welfare, educational, and religious facilities, with the churches assisting in referrals and counseling.

For Health

After studying a representative sample of households including children under 6, the California State Department of Public Health finds utilization of preventive health services—public or private—for well children inadequate in the State.

For example, in the 12 months before the study two-thirds of the children aged 1–5 did not achieve the number of physician visits for well-child services that are recommended by the American Public Health Association or the American Academy of Pediatrics, and one-third did not achieve the "bare minimum" number used by the department as an alternate standard in evaluating the data. For more than one-third of the children 3–5 years the number of visits was zero.

As another example of inadequacy in the well-child health services received by the children studied, the department points to a "distressingly low" immunization status. Less than one-third of the children had received the number of immunizations "necessary to insure their protection against diphtheria, pertussis, and tetanus."

The information was collected through hour-long visits to more than 800 households during a 10-week period in 1956, when the mothers were asked about the social and economic characteristics of the family, the child-rearing practices of the parents, the health status—physical, mental, and social—of each child, and the health supervision of the children by physicians.

The least amount of well-child health service was received by children in low-income families, those in certain ethnic groups, and those whose mothers had received little education, but children from all segments of the community fell short of the recommended care, according to the report. The department urges that the problem of providing more children with such care be a joint concern of public health and private physicians.

Single copies of the report, "Health Supervision of Young Children in California," are available to professional health workers from the California State Department of Health, Berkeley 4.

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As a result of studies made in 1958 and 1959 at the direction of the State legislature, the Massachusetts Department of Public Health has asked the legislature to establish a demonstration program for trying out methods for controlling drug addiction. The project would include an inpatient treatment program at a State hospital and a supervised outpatient program providing social casework services, vocational-guidance and rehabilitation, and psychological support. It would also include laboratory and sociological research to evaluate the project's accomplishments and make recommendations for a permanent program. The project would be coordinated with the programs of Federal, State, local, and private agencies concerned with drug addiction, as well as with educational programs for professional workers and the public. Two specific items of legislation are recommended: one to permit the use of civil rather than criminal procedures for commitment of patients; the other to require registration of drug addicts with the department of public health.

The department's report to the legislature cites a recent study by a New York State legislative committee, which shows the average age of addicts to be steadily declining.

Health Meetings

The crippled children's program of the Children's Bureau was one of the 11 recipients of Albert Lasker Awards presented by Mrs. Mary Lasker at the 88th annual meeting of the American Public Health Association at San Francisco in early November, for "significant achievement in medical science and distinguished service in public health." The citation called the program "an administrative triumph of no mean scope," which is unique in having "stimulated the extension of the highest quality of services, developing new comprehensive ones when and where needed for cardiac cripples, polio victims, amputees, the epileptic, cerebral palsied, congenitally handicapped, those with speech and hearing defects, with nephrosis and other chronic diseases."

In accepting the award for the Bureau, Dr. Arthur Lesser, director of the Bureau's Division of Health Services, pointed to the effectiveness of the program's special projects grants in providing opportunities to apply new research discoveries in the treatment of handicapped children. He also pointed out that the early appreciation in the program of the concept of the patient as an individual—or "the whole child"—provided "the basis for recognizing the significance of social and emotional factors in the care of handicapped children."

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Among the resolutions adopted by the American Public Health Association during its 88th session which were directly concerned with children were the following:

- That States provide essential health services to children without regard to the morality of their parents.
- That National and State legislation

be enacted to require adequate warning labels on hazardous plastic film products and that educational programs to acquaint the public with their danger be intensified.

- That programs for training professional health personnel for service in mental retardation work be expanded.

The Association of State and Territorial Health Officers meeting in San Francisco in the week prior to the APHA meeting adopted a resolution urging the States to adopt the health record for agricultural migrants that has been developed by the Public Health Service.

Day Care Licensing

A questionnaire sent by the Children's Bureau to all the States (including the District of Columbia, Puerto Rico, and the Virgin Islands) in preparation for the National Conference on Day Care for Children last November (see page 33) brought the following information on the licensing of day care facilities:

- Thirty-three States have laws requiring day care centers and family day care homes to be licensed; 6 States require licenses only of day care centers; 3 States require licenses of family day care homes only; 3 States have laws permitting the licensing of day care centers and family day care homes; 8 States have no responsibility for such licensing.
- Licensing responsibility, where it exists, is placed in the following departments: welfare, 33 States; health, 6; health and welfare, 3; education, 3; other, 2.
- The 39 States in which day care centers are already being licensed reported a total of 4,426 licensed centers with an aggregate capacity of 141,138 children. Of these centers 64 percent are under commercial auspices, 29 percent under voluntary auspices, 7 percent under public auspices. Fourteen States reported having licensed day care centers for mentally retarded children; 8 States, for physically handicapped children; 8 States, for children of migrant families; 5 States for emotionally disturbed children.
- The 30 States which have assumed a responsibility for licensing family day care homes reported a total of 13,577 licensed family homes with an aggregate capacity of 42,194 children; 94 percent of the homes under proprietary auspices, 1 percent under voluntary auspices, and 5 percent under public auspices.
- Twenty States set no minimum age for the children who can be admitted to the licensed day care centers; in three the minimum age is between 1½ months to a year; in 18 it is between 2 and 3 years. None of the States had set a minimum age for children in the care of licensed family day care homes.
- Thirty-two States report that licenses are not required for day care centers caring for less than a certain number of children, the minimums ranging from 2 to 11 children. Ten require licenses for day care centers no matter how few children are cared for; and 29 require licenses for all foster family day care homes. Ten States have set a minimum number of children served for which a license is required of family day care homes—the minimums ranging from 2 to 5 children.
- Forty-one of the 44 respondents to a question on need expressed the opinion that additional day care facilities were needed: especially facilities in parts of their States where few or none existed; in industrial areas to serve working mothers; low-fee facilities for families unable to pay the entire cost; facilities for disadvantaged children such as the handicapped and migrants; and family day care homes.

A preliminary report on the questionnaire containing these and other data was presented to delegates of the conference. A fuller report is to be published by the Children's Bureau later.

Juvenile Delinquency

The Welfare Council of Metropolitan Chicago recently completed a 3-year action-research project on the control of juvenile delinquency, involving intensive casework with families of troubled children, street-club work with gangs, and stimulation of citizens to improve neighborhood conditions. Its conclusion is that a coordinated program of this type can contribute to the reduction of delinquency.

As a result of the casework-with-families phase of the project the Council reports that systematic case finding, diagnosis, treatment planning, and effective steps to obtain treatment should be carried out at the neighborhood level, in harmony with other community agencies, by one central unit, supported by public funds. On the basis of ratings of children's behavior at the end of the project period it reports that among 136 of those whose families received casework treatment 20 percent showed "substantial improvement"; 45 percent, "some improvement"; and 20 per cent "no change." Eight percent were reported as "worse," and 5 percent "substantially worse."

From its project experience with gangs, the Council concludes that a street club can almost always be penetrated by the proper type of adult representative of a community agency; that such penetration is followed by an observable reduction of antisocial group behavior, though often a "hard core" of deeply maladjusted youths cannot improve with the group and are especially hard to help; that street clubs can be assisted in providing a more satisfying and sociable experience for the members; that street-club work can develop harmony between the clubs and other young people, and adults; and that it should be done by social workers who understand groupwork, casework, and community organization.

Among the 326 youths served by the three project street-club workers, the Council's record showed a reduction in delinquent behavior for 46 percent of the club members—and an increase for 13 percent. Most of those for whom the record showed "no change" had never participated in any known delinquency.

Of the 156 boys for whom no delinquency was recorded during the closing 3 months of the project, only 23 had had a clean record in the opening 3 months. Of the 83 boys originally classified as frequent participants in delinquency, 9 had shifted to the nondelinquent group, and 39 had made some progress in the right direction. However, 24 were again classified as "hard core," and 8 had been placed in institutions. Three could not be classified. All in all, 17 were institutionalized at time of the final ratings; 5 of these had been nonparticipants in delinquent acts at the time of the first recording.

In the project's community organization effort a youth welfare services steering committee was formed, representing both lay and agency interests, which worked for such measures as pooling agency efforts in a youth-employment conference and expanding fund raising for summer programs into a community-wide effort. The committee continued its efforts after the project ended.

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Four percent more persons under 18 years of age were arrested in 1959 than in 1958, according to the Federal Bureau of Investigation's Uniform Crime Report for 1959, which is based on statistics supplied by local law enforcement authorities. The report adds that the juvenile arrest rate doubled since 1948, when it was the lowest since World War II. In those 11 years, the report says, juvenile arrests increased 2½ times as much as the juvenile population increased. Such arrests make up 12 percent of all arrests in 1959.

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To determine what the Nation's churches are doing about juvenile delinquency the National Council of Churches of Christ in the United States of America has outlined a nationwide research program, at a cost of $175,000, to be completed in the spring of 1962. The proposal calls for the findings to be reported to a national interdenominational conference as a basis for program planning.

WHC Followup

A 2-day workshop on the consultation needs and resources of State committees for children and youth for followup of the White House Conference on Children and Youth was held in Washington in mid-October under the auspices of the Children's Bureau. In addition to representatives of the State committees and the Children's Bureau the participants included representatives of the National Committee for Children and Youth, the Council of National Organizations for Children and Youth, and the Federal Interdepartmental Committee on Children and Youth.

Regarding consultation as a "two-way street" the participants not only considered consultation services now available to the State committees from these organizations and means of reinforcing and expanding them, but also ways in which State committees can further the program objectives of voluntary and public programs for children and youth.

The State committees asked especially for consultation on planning, structure, and community organization, as well as on program content, and requested that this service be given by consultants skilled in community organization who would be made available to the State committees on a continuing basis.

At the request of the workshop participants, the Children's Bureau is preparing a directory of regional consultants of Federal agencies and national voluntary organizations concerned with children and youth. Also as a result of requests at the workshops, regional workshops of a similar nature are to be held in the near future.

ADC Hearing

Representatives of the Louisiana Department of Public Welfare appeared before the Commissioner of Social Security in Washington, November 14–15, in a 2-day hearing to determine whether the State's aid to dependent children program was out of conformity with the Social Security Act as a result of the dropping of nearly 6,000 families, including 22,500 children, from the rolls last July until local boards could determine whether or not they were living in "suitable homes" as defined by the Louisiana legislature. (See CHILDREN, November–December 1960, page 241.) Permission to file briefs contending that provisions of the Federal act for the protection of the children's rights were violated was requested by the representatives of a number of national voluntary organizations, including the Child Welfare League of America, the National Urban League, the Family Service Association of America, and the National Association of Social Workers.

A point questioning the constitutionality of any kind of "suitable home" requirement for Social Security Act aid was raised in the brief submitted at the beginning of the hearing by the Child Welfare League of America.

Counsel for the Department of Health, Education, and Welfare placed in the record a report prepared by its Bureau of Public Assistance on the basis of a visit to Louisiana in early October by a review team composed of Bureau of Public Assistance and Children's Bureau personnel. This report, according to Bureau of Public Assistance witnesses at the hearing, indicated that the families had been dropped from the rolls on the presumption of unsuitability of homes without any investigation of the condition of the home at the time and without being notified in writing of their right to a fair hearing. The witnesses reported that the State plan made no provision for the protection of children living in homes found to be unsuitable because of the moral conduct of the caretaker relative; also that when assistance was denied on this basis it was not permitted to be restored for the child if he went to live with another relative in an admittedly suitable home.

The State's counsel and witnesses from the State and local welfare departments contended that in complying with the 1960 Louisiana laws requiring all cases to be dropped from the rolls in which there was a "non-legal union" or in which the mother had had an illegitimate child after receiving public assistance, the State had not acted differently from a number of other States where families had been dropped from the ADC rolls because of "suitability of homes" requirements. However, counsel for the Department of Health, Education, and Welfare pointed out that other States had suspended rather than closed cases in which there was a presumption of unsuitability, and that under suspension procedure the assistance agency retained a responsibility to proceed to determine promptly whether assistance could be continued. Also, that Mississippi, a State with a law similar to Louisiana's, does not interpret it to apply retroactively.

The State also contended that each mother had been told she had a right to reapply and that reapplication was equivalent to and quicker than a "fair hearing." The State also maintained that it had revised its plan since the time it was first questioned by the Bureau of Public Assistance, and that a plan was now in effect which complies with "the moral and philosophical suggestions" of the Department of Health, Education, and Welfare by making provision for casework help for mothers whose homes are determined to be unsuitable, for assistance to children placed away from their mothers in homes of relatives, and for personal contacts by welfare department workers with those dropped families that have not reapplied "if it appears they did not understand they could reapply."

According to the State's figures, 2,300 of the dropped families, including 9,000 children, had been reinstated as of November 9. The total ADC caseload in Louisiana as of that date amounted to 20,000 families with 64,000 children. The State maintained that these could not be kept on the rolls if Federal funds were withheld.

The State and interested persons and organizations were given an opportunity to submit further briefs, and final arguments were scheduled for December 15. The decision of the Commissioner is expected to be made shortly afterwards.

Miscellaneous

A new quarterly, *DSH Abstracts*, published by the American Speech and Hearing Association with a training grant provided by the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare, appeared in October 1960. It is devoted to abstracts, study reports, and articles published in various parts of the world on hearing, hearing disorders, speech and speech disorders, and related subjects. It also includes a list of titles and authors of graduate theses on these subjects, reported by 47 colleges and universities in the United States.

Subscription rates are: $8 a year in the United States; $8.50 a year elsewhere. Single copies, $2.10 each. Order from Deafness Speech and Hearing Publications, 1001 Connecticut Avenue, NW., Washington 6, D.C.

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The House of Delegates of the Colorado Medical Society recently approved a resolution submitted by the Physicians' Adoption Committee of Denver, supporting the placement of children for adoption only through authorized adoption agencies and calling for the cooperation of lawyers, physicians, and social workers in all adoptions. Cooperative actiivty has been endorsed by the medical societies of Utah, Maryland, North Carolina, and Ohio, and by the adoption committees of the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the American Medical Association, and the American Academy of General Practice.

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A training workshop for the cerebral palsied was opened in October by the Institute for the Crippled and Disabled and United Cerebral Palsy of New York City. Two goals are set for patients admitted to the project: (1) long-term job training and employment; and (2) preparation for fuller participation in home and community life through social, educational, cultural, and spiritual activities. Twenty-five cerebral-palsied persons in their teens and early twenties are now working in the workshop. The first year of operation will be supported by a grant of $40,000 by United Cerebral Palsy.

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A play about family reaction to the subject of working wives and mothers, called "Help Wanted," planned for church groups, parent-teacher associations, women's clubs, Junior Leagues, and other social and service organizations, has been published by Human Relations Aids, 104 East 25th Street, New York 10. Single copies $1.25. Producing packets, including six copies of the script, directions for staging, and discussion guide, $5.

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At least 27 State nurses' associations now include in their bylaws the function "to develop and promote actively a program for intergroup relations," according to a report of the American Nurses' Association. Questionnaires on the subject were answered by 40 State associations.

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The International Labor Organization recently began a 6-month survey of child-labor conditions and problems of young workers in six countries in the Near and Middle East—Iraq, Iran, Israel, Lebanon, Turkey, and the United Arab Republic.

Guides and Reports

FAMILY ORGANIZATION AND CRISIS; maintenance of integration in families with a severely mentally retarded child. Bernard Farber. Monographs of the Society for Research in Child Development. Vol. 24, Serial No. 75, No. 1. Child Development Publications, Purdue University, Lafayette, Ind. 1960. 95 pp. $2.75.

Reporting on the second phase of a study of the effects of a severely mentally retarded child on the family integration of 233 Chicago families, this present monograph presents data on the strategies employed by the families to maintain their integrity in the face of the crises and describes the relation to these of the family orientation and of variables imposed by nature.

MARYLAND CHILD GROWTH AND DEVELOPMENT INSTITUTE, June 1–5, 1959. 194 pp.

Proceedings of an institute sponsored by the Children's Bureau, the Maryland State Department of Health, the Johns Hopkins University, and the University of Maryland, discussing current knowledge of the processes of growth and development in normal children and application of this knowledge to children prematurely born, those with disorders of communication, and those mentally retarded.

COOPERATIVE NURSERY SCHOOLS, A HANDBOOK FOR PARENTS; a guide for organization and administration. Montgomery County Council of Cooperative Nursery Schools, P.O. Box 1624, Wheaton, Md. 1960. 108 pp. $1.

Provides material to assist groups interested in organizing new cooperative nursery schools.

IN THE JOURNALS

Rehabilitating Delinquents

Aims for rehabilitation of a delinquent child should be adapted to the child's capability for self-determination and for relationship with the community, say a psychiatrist and two phychiatric social workers in the November 1960 issue of *Social Casework*. ("Program Development in a School for Delinquent Boys," by Thomas P. Millar, M.D., Robert J. Badman, and David Sneed.)

Six levels of child care, for children varying in their potentiality for rehabilitation are itemized in the article. They are: (1) care in the child's own home, with professional attention—probation, parole, or psychiatric treatment—from community agencies, with the child going to school in the community; (2) similar care and schooling for a child removed from the tension in his family and living in a foster-family home; (3) residential care in a small group home, not "locked," with schooling in the home or outside; (4) psychotherapy and schooling in a residential institution, sometimes custodial, with some degree of "external security or locking,"; (5) residential care and schooling in a "high security" institution—an industrial or "reform" school; (6) hospital care in a mental institution. Even if the treatment does no more than to move a child in the direction of community and home, it can be regarded as an accomplishment, according to the authors.

The authors recently completed a 2-year survey of a State school for delinquent boys at Mercer Island, Wash.

Pediatricians of the Future

The doctor who specializes in the care of children rarely sees serious illness today unless he is in one of the pediatric subspecialties, such as pediatric neurology or pediatric cardiology, says Dr. Clement A. Smith, associate professor of pediatrics, Harvard School of Medicine, in the November 12, 1960, issue of the *Journal of the American Medical Association*. ("Who Will Take Care of the Children?") Therefore, he suggests that medical students be taught about child growth and development and particularly about behavior.

Looking toward a future with more children and younger mothers, the author notes that today's mothers are willing and able "to share more of the pediatric task," than the mothers of 25 years ago, and will take a still larger part in the future. The pediatric specialist, he predicts, may find his case material even rarer if congenital malformations can be prevented, or repaired early. The pediatric generalist, he predicts, will be a doctor who really likes to care for children's minor illnesses ("which aren't minor to mothers") and to prevent most of their infectious diseases, some of their behavior disorders, and even a few of their accidental injuries.

The family's doctor of the future, the author says, will not be expected to do everything in medicine, but will help families cope with the effects of the illness of one member on all the members of the family. In this connection the author points to the eagerness with which students are participating in medical-school programs built around family care.

Abused Children

"A rare hospital phenomenon that cries dramatically for attention" is described in *Social Work* quarterly for October 1960 by Elizabeth Elmer. ("Abused Young Children Seen in Hospitals.") Every year a small number of infants and children are hospitalized with injuries caused by their own parents, or other adults responsible for them, through ignorance, gross negligence, or deliberate abuse, the author states, adding that little is known about the problem and that methods of dealing with it are "random and inadequate." What prevents a forthright attack on the problem, she maintains, is a professional blind spot, due partly to American society's repugnance for the entire subject of abused children.

The author reminds readers that it was only about 150 years ago that the stirrings of public conscience in regard to children began to be expressed by a few enlightened persons. She notes that while tremendous cultural changes have taken place since then, some families evidently have remained insulated from them, and urges study of such families.

Among a number of other questions she poses for further consideration are: How can these families be helped to provide a safe environment for their children? What is the responsibility of the physician in these cases? What are the complications for the family, the social worker, the physician, and the hospital when legal intervention is sought? What are the community resources for dealing with these families?

Sociology and Delinquency

Delinquent behavior is *not an attribute* of a person and it *must be viewed as multidimensional*, says James F. Short, Jr., of the Department of Sociology, University of Chicago, in a review of sociology's contributions to theories of delinquent behavior in the October 1960 issue of the quarterly, *Crime and Delinquency*. ("The Sociocultural Context of Delinquency.") The author, who is director of a detached worker research project, describes theories of delinquent subcultures, especially in relation to the effects on the young people within them of the availability of illegal as well as legal vocational opportunities. While pointing out that these sociological formulations have not been demonstrated scientifically, he finds some implications for programing in them. Among the attributes for an effective program he includes:

- Problems of job opportunities for youths will be dealt with on a large scale.
- The program will concern itself with the youths' personal relationships with one another, in the home, with other family members, in school, and on the job.
- In creating opportunities for legitimate status in jobs and other areas of life the program will go beyond social and psychiatric services; it will not only develop neighborhood and community leadership but will look for leadership from "business and industry, religion and politics."
- The behavioral sciences will be called upon to help motivate young people toward seeking success in legitimate opportunities.

READERS' EXCHANGE

LIVERMAN AND KENNEDY: *Refreshing and encouraging*

The family-medicine course for medical students at the University of California at Los Angeles should offer an almost ideal opportunity for social workers to introduce medical students to the principles and methods of applied sociology. ["Social Work Participation in Medical Training," by Lonis Liverman and Nathalie Kennedy, CHILDREN, November–December 1960.]

A perennial question among those who believe that the medical students' program should put more emphasis on the social aspects of medicine and on the normal range of growth and development is when to do it. The first 2, or basic science, years are frequently considered as undesirable because the student is chiefly an onlooker and is not yet trained to partake of the work of diagnosis and treatment. But the medical school at UCLA has taken advantage of the fact that the very lack of clinical contact in the first 2 years of the classical program whets the student's appetite and makes this one of the best possible periods to have him act as observer of and recorder for a family with a newborn baby. Thus the student sharpens his abilities as an observer and history taker and, more important, sees something of the home life of clinic patients and of the effect of home, nursery, and school environment on the growing child in health and illness. (Too many medical students rarely or never set foot inside the homes or get an understanding of the family problems of the clinic patients who bulk so large in their medical training.)

This process is continued in the second year, when each student is assigned another family as part of his introduction to physical diagnosis. The home visit is again used to emphasize the importance of the family and social situations.

All of this is encouraging to those of us who believe that the present day medical curriculum tends to neglect these aspects of medicine.

The social worker and the applied sociologist are essential participants along with physicians, nurses, and others in this work.

Paul A. Harper, M.D.
Professor of Public Health Administration, Maternal and Child Health Division, Johns Hopkins University, Baltimore, Md.

Similarities in program

In reading the article by Lonis Liverman and Nathalie Kennedy, social workers participating in various programs of medical schools will be struck with the similarities to their own programs, especially in relation to the student response to content dealing with the social and emotional forces which affect medical care and to social work participation in helping the student integrate this content. These similarities exist despite the differences in structure and implementation of the courses or programs serving as the "vehicle" for this teaching.

In some programs the medical student is chiefly an observer; in others, he may be more of a doer, with ongoing activities and responsibilities in relation to the patient's medical program. Attention is frequently focused on these differences among the programs, and opinions vary as to the merits of each. Student anxiety is often believed greater when the student has more activity in the actual medical program than when he is chiefly an observer. As brought out in the Liverman-Kennedy article, the student-observer role is also anxiety provoking.

Whether the student is chiefly an observer or a doer, such programs give recognition to this common response and to the task of helping him with the subtleties of interviewing techniques; with understanding the meaning of his observations of behavior and personality, family relationships, social situations; and with a beginning awareness of his own attitudes and reactions and of integration of theory with practice. Through discussion with his teachers and his own peer group, the student's integration of his new understanding and skills is facilitated and deepened.

The similarity in social work participation stems from the long experience of the social work field in the preparation of its students in a profession utilizing techniques of interviewing, understanding dynamics of behavior, and understanding of one's own attitudes. As was mentioned by the authors in another context, these are not the province solely of social work; but as these are its chief "tools" which are taught to social work students, the social work profession has a particular contribution to make with other instructors in the teaching of the medical student in these areas.

Dorothea Chickering
Associate in Social Work, School of Medicine, Western Reserve University, Cleveland

PEAY: *A nurse's comments*

Roberta Peay's article reflects a breadth of vision which must be taken into account if we are to prevent the natural by-products of physical abnormality and illness from impeding the child's progress toward optimal health. ["Emotional Problems of Children Facing Heart Surgery," CHILDREN, November-December 1960.] Miss Peay not only focused my attention on the problems of the child and his parents during the period of surgical intervention, but also on the importance of seeing that parents get the professional help they need at the time the diagnosis of congenital heart disease is first made and when they are confronted with the surgeon's recommendations.

In our struggle to cope with the multitude of important and urgent nursing problems rising out of rapid advancement in the field of cardiac surgery, we nurses must not lose sight of the opportunity we have to assist in important preventive work, which may well have more far-reaching effects in promoting recovery from an operation and on postoperative adjustment than we now realize. Procedures such as cardiac catheterization and angiocardiograms are often viewed as simple procedures, and in comparison to open-heart surgical intervention they are. Yet, as Miss Peay suggests, these diagnostic procedures are of great import to both the child and his parents.

Such procedures should be important to nurses as well, for they provide avenues through which constructive attitudes and feelings toward hospital personnel and toward later treatment can be acquired. Often these procedures are carried out during the child's and parents' first experience with personnel in a pediatric ward and with operative techniques. If the child's feelings and need for preparation are taken into account and he is thoughtfully supported through the experience, he will be better prepared to cooperate when the necessity for uncomfortable postoperative procedures must be faced.

For the parents the period of waiting for the doctor's diagnosis and recommendations may be as anxiety provoking as waiting for news concerning the outcome of open-heart surgery. If so, help at this point must be provided not only to lessen the immediate suffering but also to help the parents become mobilized for coping with the bigger problems which lie ahead.

Miss Peay points out that *all* members of the health team must be available to parents who are faced with the grave findings of diagnostic procedures, that "no one professional discipline can provide adequate help alone." And how true this is—not only at the time when recommendations are being made but also throughout the entire period of a health problem's existence. Only as we nurses learn to use others of the health team to gain deeper understanding of the needs of both child and parents will our unique contribution become fully expanded and developed to the point where we are truly helpful to troubled children and parents.

Florence G. Blake
Associate Professor of Nursing Education, University of Chicago

Correction

Roberta Peay, author of "Emotional Problems of Children Facing Heart Surgery," discussed in the foregoing letters, is associated with the National Heart Institute and not the National Institute of Mental Health as incorrectly stated in her biographical sketch on the authors' page of the November-December 1960 issue of CHILDREN.

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Page 11, American Foundation for the Blind, New York.

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International Publications

CHILD GUIDANCE CENTRES. D. Buckle and S. Lebovici. World Health Organization, Geneva. 1960. WHO Monograph Series No. 40. 133 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27. $4.

This monograph is based on a seminar held in 1956 in Lausanne, Switzerland, under the auspices of the Regional Office for Europe of the World Health Organization, attended by mental health administrators and team members of child guidance centers from eight European countries. Among the aspects of child guidance it discusses are: the case history; teamwork among the various types of professional workers involved and training for child guidance work; diagnosis, classification, and treatment of disorders; case finding; external relations of the child guidance center; and factors to be considered in the establishment of new centers.

The monograph notes that the modern conception of child guidance includes a diagnosis of the whole family after each of its members has been examined both as an individual and in his relationship to the others.

The participants in the seminar came from Greece, Italy, Portugal, Spain, Turkey, Yugoslavia, Belgium, and Switzerland.

DEMOGRAPHIC YEARBOOK. 1959, eleventh issue. Statistical Office, Department of Economic and Social Affairs, United Nations. 1960. 723 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27. $8 paperbound; $10 clothbound.

The special topic of the eleventh Demographic Yearbook is natality statistics. They cover 10-year trends of live births in relation to such factors as age of mother and of father, legitimacy, sex, birth order, and duration of marriage. Similar trends are covered for late fetal deaths in reference to maternal age, birth order, and legitimacy, and for all fetal deaths according to period of gestation.

The statistics show that the world average of regional birth rates is 35 per 1,000 population, ranging from 46 per 1,000 in tropical and southern Africa, and in southeast Asia, to 18 per 1,000 in north and west Europe.

The data indicate that the population of the world is increasing at an annual rate of 1.7 percent. The current world birth rate adds 100 million babies a year to the population while death removes 51 million persons, leaving the net annual gain at somewhat over 48 million inhabitants. Population is increasing fastest in "Middle America," where birth rates have remained high while mortality levels have dropped.

A review of age-specific birth rates in 10 countries between 1949 and 1959 suggested that at least in Europe, the postwar trend toward larger families has slackened. While the rate of birth for women in the 20–24 year age group has been on the increase in many countries, this is interpreted for industrialized countries as a possible reflection of the trend toward earlier marriage.

Data on infant mortality are reported from 158 geographic units. A variety of limitations on comparability of infant mortality rates are described: for example, compilation of the deaths and births by date of registration without regard to date of occurrence, under-registration of births and deaths, differences in geographic and ethnic coverage, differences in statistical definitions, and differences in tabulation procedures.

Among all countries reporting vital statistics stated to be at least 90 percent complete, in accordance with United Nations definitions, and for a total population greater than 300,000, Sweden had the lowest infant death rate in 1958 (15.8 per 1,000 live births), as well as in 1950. The United States, with a rate of 27.1, is 10th among the 15 countries with the lowest rates.

Cause-of-death statistics, without regard to age, for the latest year available are also set forth for 66 geographic areas. Mortality associated with childbearing was lowest in Sweden, where a rate of 3.5 per 10,000 live births was reported for 1957.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

DAY CARE SERVICES. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 51. 1960. 62 pp. 25 cents.

A popularly written pamphlet, with case illustrations, which explains why day care centers or family day care homes are needed for many children, what the functions of these facilities are, and how communities can take steps toward providing them.

CHILDREN OF WORKING MOTHERS. Elizabeth Herzog. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 382. 1960. 38 pp. 20 cents.

Presents facts and figures about the number of mothers employed, full time or part time; their marital status; the number of children involved; ages of their children; income; and reviews studies of the effects of the mother's employment on the family. Suggests that the mother's working outside the home in itself may well be a secondary factor affecting her children, and names as primary factors the type of child care arrangements; the way the child reacts to the mother's absence; and the parents' attitudes and behavior, including specific reactions to the mother's working.

DAY CARE OF CHILDREN UNDER 12: findings of a survey on the resources of national organizations, as reported to the Women's Bureau and to the Children's Bureau in March 1959. Department of Labor, Women's Bureau; and Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960. 21 pp.

This publication is based on answers to a questionnaire sent to national organizations by the Women's Bureau and the Children's Bureau.

Among the activities reported to the Women's Bureau by 150 organizations were: actual establishment and operation of day-care centers, promotion of legislative standards for their operation, furnishing consultant service, financial assistance, teachers' aides, and volunteer workers to centers, sponsoring educational programs for day-care personnel, and carrying on research to find data for educational and legislative programs.

Among the activities reported to the Children's Bureau by 39 organizations were: promoting needed services, setting standards, improving quality of existing facilities, raising funds, planning on a community or regional basis, community surveys of need for service, providing facilities, protecting the health of the child and his caretaker, establishing sound educational programs, and creating interest in the special needs of handicapped children.

FOOD FOR GROUPS OF YOUNG CHILDREN CARED FOR DURING THE DAY. Helen M. Hille. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 386. 1960. 58 pp. 25 cents.

Offers suggestions on developing good eating habits in children in day care; meeting their nutritional needs; planning menus; purchasing, preparing, and serving foods; and making mealtime pleasant. Includes sample record forms for market orders, inventories of food supplies, standardized recipes, and calculating raw food costs per person per meal.

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The Effects of Handicaps

Attitudes Toward Foster Care

Protecting the Newborn

Training Schools and Community

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◀

A NURSING MOTHER. Though the psychological and physical values of breast feeding the newborn are becoming increasingly recognized, outbreaks of staphylococcal infections in hospitals in recent years have made the nursing mother a star figure in a conflict between two philosophies of postpartal care. One regards breast feeding and other contacts between the newborn and adults as dangerous methods of spreading infection and the other regards the psychological needs of mothers and infants as too important to ignore. The opposing arguments and some suggestions for compromise are presented in the article on page 53.

◄ *the authors*

A psychiatrist working in the field of public health, Paul V. Lemkau is concerned with finding ways applicable to large populations for enhancing the normal development of personality. This has led to studies of the epidemiology of mental disease, the effect of obstetrical accidents on the child's behavior and on child-parent relationships, and of the administration of mental health programs.

Kenneth Dick has been assistant executive director for 2 of the 12 years he has been on the staff of the Family and Children's Service of Greater St. Louis. A graduate of the St. Louis University School of Social Work, he has also been teaching research there for the past 5 years. He is author of a number of articles on child welfare and family casework, which appeared in professional journals.

Author of the volume, "Aseptic Nursing Techniques," Margaret Thomas recently spent a year on loan to the Communicable Disease Center, Public Health Service, working on problems of staphylococcus control in hospitals, particularly in nurseries for the newborn. A nurse-midwife with master's degrees in public health nursing and in public health administration, she has been on the staff of the Children's Bureau for 15 years.

Ethel D. Mecum's first experience in institutional work was as an undergraduate one summer at the Massachusetts Reformatory for Women. At the Long Lane School, the Connecticut State training school for girls, she was first a social worker, then supervisor of social service before becoming superintendent in 1954. She is president of the National Association of Training Schools and Juvenile Agencies.

A graduate of the Pennsylvania School of Social Work, Miriam O. Page started her social work career with the Children's Bureau of Philadelphia in 1935. During World War II, she served with the American Red Cross in hospitals overseas. After doing training and supervision in the State welfare departments of New York and New Hampshire, she joined the Vermont Department of Social Welfare as training consultant in 1955.

For 3 years before he assumed his present post in 1953, Alfred L. Baldwin was chairman of the Department of Psychology of the University of Kansas. Previously he was on the faculty of Antioch College and was associated with the National Defense Research Center, Yale University. He is author of the book, "Behavior and Development of Children," published by Holt-Dryden in 1955.

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THE INFLUENCE OF HANDICAPPING CONDITIONS ON CHILD DEVELOPMENT

PAUL V. LEMKAU, M.D.
Professor of Mental Hygiene, Johns Hopkins University

WHAT DOES IT DO to a child never to have had the opportunity to chase a butterfly? Or never to have been able to read "The Three Little Pigs" or "Cinderella", but only to have heard the stories? What happens to a child's nervous system—made to receive, assimilate, and interpret a full range of sound frequencies—when it can only get a limited range of damped frequencies to work with because the child can hear only parts of sounds? What does it do to a child if he gets a low return on his efforts to communicate with others because of a speech defect?

Does the constant bombardment of a brain by muscle-sense perceptions from the incessant movements of a hyperactive child lead to the development of protective patterns of nonresponse? And does such nonresponse spread and account for inattention to sensory perceptions from ears and eyes so that the youngster is unable to concentrate on anything? Can a retarded child's central nervous system, which has multiple functions, only a few of which may be operating defectively, adjust to the imbalance caused by the blocking of one or another integrative channel?

In other words, what difference to the child's total personality does an imbalance in "input" from the senses really make? What difference can a deficit of a few billion input impulses from one direction or another make in the total integration of a few billion functioning cells in the central nervous system?

The writer of this article certainly cannot answer all these questions, and it is doubtful whether anyone can do so at this moment of scientific history. But they are questions appropriate to a discussion of the possible influence of handicapping conditions on the child.

Attitudes toward handicapping conditions are changing under the impact of new scientific findings. We used to approach handicapped children mainly with sympathy, trying to imagine what life must be like for them. Sometimes, we tore our hearts out to give them more of something, including compassion, in order to make them feel less different and less deprived, and often, too, to make ourselves feel less guilty in our inability to relieve their defects appreciably. This often led to oversolicitous, protective care which prevented the child from receiving the stimuli he needed.

The quality of sympathy and compassion is needed no less now than it was in the past. But there is new information to deal with, and there are new concepts to be applied in thinking about the effect of handicaps. Attitudes of sympathy need to be supplemented with interpretations from the scientific field that may make our compassion more effective in helping the handicapped person to achieve a more complete range of experience.

According to the stimulus-response theory of personality formation, the individual can be nothing except what his experience, in interaction with his physical inheritance, has made him. One who has never seen can have no conception of what "seeing" in the literal sense is. Unless there is a stimulus, there can be no response to be elaborated and integrated into thoughts, word pictures, symbols, and all the other things that the human brain can produce.

The stimulus-response theory needs a great deal of elaboration to fit the actual facts. Such elaboration, however, is not needed for the main point to be made here: the importance of providing a handicapped child with as much as possible of the variety of stimuli to which a normal child is subjected.

It is important to remember that because of the great variety of inherited traits and capacities, human variation is very great. The effect of a stimulus is not the same on every organism unless the organism itself is identical with every other in a series. This does not happen anywhere in biology and certainly not in human beings.

Deprivation of Stimulus

Until fairly recently psychology and physiology tended to run along side by side without coming together at any point. Physiology prided itself on dealing with demonstrable changes, the pull of a muscle, an action current, or a chemical change. Psychology tended to be concerned with thoughts and feelings, phenomena which, in general, tended to be extremely hard to measure. The amalgamation of these two streams of information into a unified science has been very hard to accomplish. The problem of getting the two together, known in philosophy as "the mind-body problem," has provoked various analogies over the years. Some persons have talked of the parallelism of things happening in the body with things happening in the mind and vice versa. Others have spoken of the two "aspects" of interpreting the same action, the "aspect" of thought and feeling and that of the physiological concomitant of thought and feeling; and again, vice versa.

Psychology has been beset by having to speak very often in terms of analogy. Mental deficiency has been called a handicap *like* an amputation. Poor pronunciation has been called a handicap *like* a limp. Inability to interpret sounds has been regarded as similar to the inability to hear sounds at all.

Some progress has been made in finding the relationship of psychological symptoms to physiological facts, so that there are areas now where the psychologist does not have to use analogy, where he can say, "I am not talking about something that is similar to a physiological phenomenon but of something that is the same and has the same scientific validity." The advances that have made this possible have come mainly from experiments on deprivation of stimulation—deliberate experiments with animals, and, with humans, observation of the effects of deprivation that has already occurred.

For example, it has been known for a long time that people with severe strabismus end up with an eye which cannot see even though it started out as a structurally sound eye. This is called amblyopia exanopsia, and it is prevented—while awaiting time for a corrective operation—by deliberately interfering with the vision of each eye alternately so that both eyes must be used part of the time. The explanation for the loss of vision in the unused eye appears to be that the brain neglects the stimulus it furnishes, since two images are confusing; and the result is that the neglected eye eventually becomes unable to send out stimuli at all.

Animal experimentation shows that if the eye is not allowed to receive light at all, that is, does not have the opportunity to receive its normal stimulus, it will eventually be unable to receive a stimulus adequately, and the animal will not have useful vision. Some research workers have found that this is related to the fact that light falling on the retina is necessary to stimulate the formation of certain chemical substances essential for vision.[1] Once this sort of blindness is induced, it does not recover easily; indeed, if the animal is not exposed to light during a certain "critical" period, it will always be blind. The capacity to see appears to be lost unless it is used.

Years ago it was found that if babies admitted to pediatric hospitals because of acute infectious diseases were not sent home immediately upon recovery, they developed marasmus, a condition characterized by loss of muscle tone, low-grade fever, low hemoglobin, usually marked loss of weight, chronic diarrhea and, finally, a great under-responsiveness and lethargy. Lest you have forgotten that this existed, look at the awful pictures of such children Chapin published in 1908.[2] The cure for this condition was to send the baby home to be stimulated by the attention and activities normal in most families but lacking in hospital wards visited only by doctors and nurses. In these infants apparently the whole child was responding to lack of stimulation in the same way the eye reacted to a deprivation of light—by becoming useless, by dying.[3]

The slow process by which this idea found its way into hospital administration is now history. The result can now be seen in bright, stimulating pediatric wards populated not only by patients, nurses, and doctors but also by play therapists, occupational therapists and, more and more, by the children's own parents. One objective of these changes is to prevent children from dying from understimulation.

Unbalanced Stimulation

A great deal of research carried on in recent years has been concerned with more subtle effects of understimulation than the massive marasmus described by Chapin. Bowlby [4] collected most of these studies made before 1951 in his book, "Maternal Care and Mental Health." He maintains that children deprived of proper parental care in infancy and early childhood show an irreversible trait of "affectionlessness," an inability to establish an affectionate relationship with others. There is much less scientific certainty about such subtle deficits than there is about the overwhelming deprivations of the old pediatric hospital or the kind of orphanage Dickens might have described. Nevertheless Bowlby's work tends to confirm the theory that deprivation of stimulation if continued long enough means loss of function. This theory is of tremendous importance in understanding the effects of handicaps on children.

Every handicapped child is a child deprived of certain experiences. The range of the deprivation goes from that experienced by a bed-fast, blind, and deaf idiot—about the maximum deprivation compatible with life—to that experienced by a child with a slight limp deprived only perhaps of being able to win a foot race. The problem for the person who wishes to preserve as much as possible the normal development of the personality of the handicapped child is to see to it that the deprivations, and understimulation he suffers are minimal. Thus the maximal restoration and preservation of function becomes the first priority for attention in almost all cases.

The brain is put together so that it can integrate and make meaningful the information brought in through the senses, including muscle and position senses. In a normal person this information is pouring into the brain all the time a person is awake. Some of the information gets into consciousness and is recognized as a particular feeling or sensation. Other items in the stream of inflowing information need not come to consciousness at all to be effective in influencing behavior. For example, the balancing and muscle sense items that make walking possible come in and lead to adjustments of position quite automatically without reaching consciousness.

Blind children waiting their turn at a playground slide. Play with other children can help lessen the experience deficit which so often complicates the effects on the personality of the deprivation of such an important sense as sight.

Normally, this inflow of sensory input is in a certain balance, each sense with the other. We do not know today exactly what this balance is nor can we make quantitative measurements of how much sight and how much hearing and how much taste and smell or balance and position sense enter the normal inflow, but we do know that the normal brain is equipped to handle it and make it meaningful.

Suppose now that this balanced inflow is interfered with by decreased sight or hearing. This represents a loss of stimulation, a deprivation of experience to the individual concerned. That part of his brain used to "integrate" the material from these senses would also be understimulated. If the insufficiency of stimulation at this internal level were severe enough and came during a "critical" period of his development, there might well result a failure to develop the function of integration, which adds meaning to experience, just as the unused eye fails to develop its function of seeing. Fortunately the brain appears to act for many purposes as though

Deprived of a normal sense of hearing, these children learn to make the sounds of speech. Failure to receive communication signals during the early period of language formation may damage the deaf child's ability to learn communication skills.

its functional connections were very widespread. Probably because of this, the integration function appears not to suffer too much from the deprivation of input from a single sense.

On the basis of this theory, the first concern in preventing disordered personality development in handicapped children is the maximal restoration of sensory input. It is necessary to preserve as far as possible the balance of input of sensory data to the brain since the brain is adjusted to such sensory balance. Detailed research to test the theory remains, for the most part, yet to be done.

The balance of input can be disturbed by lack of vision or deafness, but it can also be disturbed by an overabundance of one or another kind of sensation. Such overabundance of input in vision is uncommon. But one of the troubles of hard of hearing persons who use hearing aids appears to be an overabundance of noise which the brain finds it difficult to separate into what is meaningful and what is meaningless. Another type of overstimulation occurs in cerebral palsy, with or without spontaneous, unpredictable movements.

In this condition the musculature is likely to be more tense than normal and a pitching struggle for balance continually goes on. The proprioceptors in the muscles are constantly bombarded by impulses due to the tension, the random movements, the struggle to adjust the muscle to maintain balance. What a stream of proprioceptive input must come from all this poorly coordinated movement and how different it must be from the proprioceptive inflow in the normal person! How much it must overbalance sight and vision as compared with the normal! Is it any wonder that the effort to interpret this inflow puts the familiar expression of intense concentration on the faces of little children with cerebral palsy who are being taught to walk? Is it any wonder that with such abnormal input the personality might also be disturbed?

Obviously we can think about any sort of motor disability in this way. The differences are more in a quantitative than in a qualitative direction.

No impluse can originate from an amputated limb, yet the "balance of input" seems to demand them so strongly that many amputees find the central nervous system produces them itself. They suffer from pain or fatigue in the limb that is gone so definitely that medicine invented the term "phantom limb" to describe the sensations. Similarly one can imagine that the jolt of a limping gait adds more impulses for nervous system integration than a smooth pattern of walking. The subtleties of the differences made by these varied patterns of stimulus-input balance is, again, largely a matter for future research.

The Effect of Time

Many observers have noted that the stage of development at which a handicap appears makes a great deal of difference in the effect on handicapped person.[5] The usual conclusion is that the earlier in life the disability appears the less likely it is to disturb personality functioning.

The phantom limb previously discussed disappears after a few months. The nervous system seems to be able, after a while, to adapt to the loss of incoming stimuli from that area of the body. Put into the usual scientific language, the statement is that the "body image," the concept one has of how he looks and is, has become adapted to the loss of the limb. It is likely that in a nonhearing or nonseeing child whose defect was present at birth or soon after, the "body image" never included the lost sense, and adjustment to the loss was never required. When deprivation of a sense comes later, adjustment of "body image" is necessary; making the adjustment then appears to induce more severe personality disorder in the deprived person.

Very early or congenital loss of hearing may be an exception to this general conclusion, quite possibly because the absence of the input of hearing signals to the brain during the critical period for language formation leaves a damaged capacity for learning communication skills. Incidentally, it may well be that the lesser efficiency of communication by "finger talk" as compared with even an impaired auditory signal may be due to the fact that the manual dexterity necessary for sign language is not within the capacity of the child until after the age at which communication capacity may have passed the optimum point of its critical period for development. Such speculation demonstrates how complex these problems are.

Another type of handicap must be considered. This is present in some children who do not show any physical incoordination nor even any easily observable sensory loss. Examples are the motor hyperactivity of some brain-damaged children and the many sorts of thinking and learning difficulties, such as inability to handle abstract symbols and ideas, some types of reading disability, or mathematical disability of children who do not, through the usual tests, show evidence of organic damage. Included in this group, probably, are those children Drs. Hardy and Pauls [6] have been concerned about, who can hear sounds but are unable to attach meaning to them. The group also includes a category very difficult to fit into any theory; those mental defectives whose condition defies any more exact diagnosis.

As far as can presently be judged, the children with these various symptoms are suffering from a block of the integrative processes within the brain.

There is a tremendous amount of research to be done in this area, laboratory research on brain structure and function as well as clinical examination which will more clearly identify the defects being dealt with. Research in the last decade or two has demonstrated that there are many more cases of mild or minimal brain damage among the nondescript group of cases frequently labeled "behavior problems" and "mental defectives" than had previously been suspected. In these cases the conditions may be interpretable as coming from insufficient, excessive, or unbalanced input of signals impinging upon the remaining normally functioning brain.

A case of this sort of handicap, showing the kinds of problems unbalanced functioning present in everyday life, has recently come to my attention. This concerns a child who is known to have suffered brain damage at some time early in life, perhaps during intra-uterine existence. There is some general retardation but reading ability is almost up to age-grade level. This preadolescent youngster is out of step with her age mates; those who read at her level are not interested in the simple games and doll play that interest her. She fits in no place socially and is lonesome and, to some extent, isolated by this peculiar imbalance of abilities.

This article began with some words about compassion, pointing out that, for many conditions, compassion may now be reinforced with better knowledge and more complete theory. Perhaps it is wise to point out also that, in practice, treatment and management are often based on compassion and sympathy long before knowledge and theory have caught up with the problem. The protection of children from the unstimulating atmosphere of the old-time institution came through a reform movement to provide care for homeless children in foster homes a long time before even Chapin's significant work was published.

Compassion certainly dictates that, for handicapped children, the maximal use of normal channels of input should be made, though acceptance of this idea is not yet universal in regard to all types of handicaps. There have been sharp differences of opinion on the issue of whether hearing aids should replace sign language for children with severe hearing loss. However, there is almost no difference of opinion about the wisdom of following this policy in regard to children with visual handicaps. The same is true of children with crippling conditions.

Knowledge and informed theory can keep compassion working at maximal efficiency.

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[1] Hayden, H.: Histological factors in behavior changes. Address delivered at the opening ceremonies of the Psychiatric Institute, University of Maryland School of Medicine, Baltimore, November 18, 1952.

[2] Chapin, H. D.: A plan of dealing with atrophic infants and children. *Archives of Pediatrics*, July 1908.

[3] Lemkau, P. V.: Basic issues in psychiatry. Charles C Thomas, Springfield, Ill., 1959.

[4] Bowlby, John: Maternal care and mental health. World Health Organization, Geneva, 1951.

[5] Barker, R. G.; Wright, B. A.; Meyerson, L.; Gonick, M. M.: Adjustment to physical handicap and illness; a survey of the social psychology of physique and disability. Social Science Research Council, New York, 1953.

[6] Hardy, William G.; Pauls, Miriam D.: Atypical children with communicative disorders. *Children*, January–February 1959.

Implications for foster home recruitment emerge from a St. Louis survey of . . .

WHAT PEOPLE THINK ABOUT FOSTER CARE

KENNETH DICK
Assistant Executive Director, Family and Children's Service of Greater St. Louis

THE HOPE of learning something about public attitudes on foster care, that would be of value to agencies recruiting homes to board children, was the stimulus for a survey conducted by the St. Louis University School of Social Service in 1959. Cooperating in the study were the Children's Services of St. Louis, Family and Children's Service of Greater St. Louis, which suggested the survey, the Catholic Charities, and the Child Welfare Services of St. Louis County. The findings revealed that attitudes believed by the agencies to be inhibiting people from boarding children—disapproval by friends and relatives, visits by the child's parents, and low payment for board—were actually lower in intensity than expected. Rather, the common attitudes were expressed by statements such as "we don't want to be bothered," or "agencies expect too much of people." These replies and the apparent lack of accurate information about child placing agencies present a challenge to agencies planning homefinding activities.

From addresses provided by three of the four cooperating agencies, we plotted the areas in the city and county with a high concentration of boarding homes, separately for white and for Negro foster families. From these areas, a total of 50 blocks were chosen—25 blocks each for white and Negro—and in each block a nonfoster family was selected at random for interviewing. The other half of the sample, also equally divided between Negro and white families, was selected from sections of the city and county in which the four agencies had indicated that their recruitment efforts were meeting with little success. This type of sampling enabled us to analyze racial differences and to compare families with some chance of exposure to agency programs with families that theoretically do not have that chance. In all, 100 persons from 100 blocks were interviewed.

Except for questions about foster parents or foster children, direct questions regarding what they knew about or thought of foster care were not asked the persons interviewed. Instead they were presented with two hypothetical situations—parents needing to place their children and a family boarding a child—around which sets of problems were constructed. The respondents were asked to give their opinions on these problems or tell what advice they would give to a friend faced with a decision in regard to them. From the replies, certain attitudes and knowledge or lack of knowledge about foster care were inferred.

We do not maintain that these responses reflect the attitudes or knowledge in the total community. We recognize the limitations of a sample of 100 and the hazards of public opinion interviewing. The findings may have value, however, as clues to understanding the problems of homefinding.

Some agency publicity was found to be trickling through to the public but not in the amount or of the kind to kindle a desire in people to become foster parents or to make clear exactly what it is that the placement agencies are doing.

Less than half of the 100 people interviewed had heard, read, or seen any publicity about the agencies' need for foster homes. Furthermore, they were not inclined to believe that the need existed, or that the agencies would have a hard time finding sufficient homes to care for homeless children. Yet these persons were interviewed at a time when special newspaper features, spot radio and television announcements, and special speakers were appealing for homes to place the children who were in the care of these agencies.

Lack of Responsiveness

Another, even more serious aspect of the problem was uncovered. When agency publicity did get through, it did not touch a responsive chord. Not only did the publicity fail to reach half the people but those it did reach often could not remember the name of the agency or the major elements of the publicity. Many interviewees said that not enough was told about either the agencies or the children, and that there was not enough heart appeal to make them want to know more.

On the other hand, nearly half the people interviewed said they would like to hear more about foster home programs or children needing homes. They belonged to clubs, church groups, or PTA's which they thought would welcome a speaker; but, as one woman commented, they "wouldn't know how to go about getting a speaker."

Herein lies the challenge to placement agencies. People want to know more, and at the same time agency publicity is failing to reach or impress them. New methods and a new focus are therefore called for. But will the publicity techniques that sell cigarettes, toothpaste, or nail polish do the job? There is no popular image of the agencies that makes them a "household item." Nor is their work generally controversial or sensational. Newspapers, radio, and television may arouse the public on political, racial, and other "hot" issues, but can they alone achieve the desired results for agencies reaching out for foster homes?

The problem apparently is more complicated than catching eyes or ears. The anxieties or fears of potential foster parents about agencies, as well as their motivations and their understanding, obviously play an important part in their reactions.

In neighborhoods of many foster homes, interviewees who had known foster parents remembered things about the child and his parents but were confused about the agency's part in the picture. They saw little difference between foster children and other children in the neighborhood. When they did see the child as different, the difference they mentioned was usually shyness, lack of self-confidence, or a physical handicap. Few mentioned the acting-out child; most tended to be tolerant of his behavior. Therefore, we might imply that foster children were acceptable in neighborhoods in which an awareness existed of what foster parents do. The opposite was found in neighborhoods of few boarding homes. There the residents often considered the foster child as something apart and potentially a problem.

The respondents were less certain in their thinking about why children need to be separated from their parents and placed in foster homes. This may be a factor that is overlooked in the recruitment of homes. In commenting on the hypothetical situations presented, 16 percent of the sample expressed the opinion that a child should not be placed away from home under any circumstances except for adoption. Among them was a professional woman who commented that "Taking a child from his parents does nothing for him; it only magnifies his problems." Such attitudes are similar to findings in the recent study by the Child Welfare League of America.[1] For the other 84 percent, broken homes, morally unfit parents, working parents, and parents unable to support the child, in that order, ranked highest as the reasons given for separating a child from his parents. To help or treat a child was mentioned by only one person. On the other hand, when questions about the reasons for boarding children were asked directly, "to help the child"—provided he was homeless—became significant.

Motivations

Most of the people interviewed considered foster parents as having healthy motives for boarding children. The simple love of children was the outstanding reason given, particularly in neighborhoods with a high concentration of boarding homes. Persons who mentioned this also saw foster parents as having a giving nature and a desire to help a homeless child.

The financial motive for foster parenthood, though important, was stressed less often than we had expected. It was greatest in the neighborhoods in which the recruitment efforts of agencies had met with least success. We were also surprised to find that the opportunity to help a child who needed to be separated from his parents temporarily for study and treatment had almost no appeal.

Although the concept of love of children and the willingness to give of oneself may be an oversimplification of the actual motives of foster parents, it is the essence of a positive approach to foster parenthood. Caseworkers assume that positive motivations, though sometimes cloaking negative needs, do exist. A corollary to this is the fact that people derive "healthy" satisfactions from the service they give a child and an agency. More attention to these aspects of recruitment might enable the child-placing agencies to reach more people who have the precious gift of love and understanding to offer a child. There is the need to probe deeper into the meaning of this love to the foster parents themselves and into the conscious satisfactions the experience of foster parenthood brings them. Interest in this subject has led the Family and Children's Service of Greater St. Louis to consider making a study of this among persons boarding children.

When we tried to get at the reasons why it is hard to interest people in becoming foster parents, we found, as might be expected, an opposite set of factors. Selfish motives predominated, such as, "I don't want to be bothered" and "It's too much responsibility; agencies expect too much of people." These comments reflected the attitudes of nearly half of the 57 people who said they thought agencies would have difficulty in recruiting boarding homes. Other important reasons were that people had children of their own to take care of and that board payments were considered inadequate.

Further questions gave some insight into the unwillingness to be bothered. In 40 percent of the families interviewed, the woman was working. Slightly less than a third of this group indicated they might be interested in boarding a child if they were not employed. Two-thirds of all the families had school-age children. In about a fourth of these, the parents said they might like to become foster parents when their children are older. And finally, a third of all the people interviewed might be interested if they had more room.

There may, however, be something more to this unwillingness to be bothered. Perhaps the equilibrium of these people's lives, the solidarity of the family, and the satisfactions achieved in it outweigh the factors that might lead them to want to board children. Herein may lie the dilemma of the agencies: the people with the best potential for foster parenthood are the hardest to motivate. If so, what significance for recruitment programs lies in the combined tendencies of interviewees to feel that boarding children is too much responsibility and that agencies expect too much of people? Do these attitudes indicate that desirable applicants do not take the first step toward foster parenthood because an unwillingness to take on added responsibility or to be bothered outweighs their love for children and any potential satisfactions from boarding children?

Attitudes Toward the Agency

The study did not bring out the usual stereotype of the social worker that we sometimes think exists. Nor was a great deal of hostility to social workers apparent. What hostility did exist was occasionally bitterly expressed and was more often directed toward the agency than against the social worker. In discussing the hypothetical foster home situations, only 10 percent of the interviewees said they would object to the visits of a social worker. More significant, a third, composed largely of people tending to be vague and lacking understanding of agency programs, said it would make no difference to them whether or not a social worker visited. The remaining 57 percent indicated they would welcome the visits of the social worker and at times might seek his help.

There was also a disappointing confusion about the role of the agency, especially among people who had seen agency programs in operation. In this group, with more doubts than those in other neighborhoods about what the agencies were trying to accomplish, the point was frequently raised that too much was expected of foster parents. Maybe this was a factor in the widely expressed preference in this group for boarding children independently of a social agency. Undoubtedly a latent anxiety and fear of agencies as well as feelings of insecurity on the part of the interviewees may have contributed to these attitudes. However, it raises the question of how much effort is expended in educating foster parents on the problems and the role of the child-placing agency. In this connection, the Family and Children's Service decided in 1959 to inaugurate a group training program for foster parents.

Slightly more than half of the total sample said they would prefer to board children for an agency. The major reasons given for this preference were that: (1) there would be less interference from parents—"things go smoother"; (2) the agency helps the child and foster parents with their problems; (3) the agency protects the foster family and is more dependable than the child's parents themselves are apt to be.

The people who said they would prefer to board independently based their preference on the belief that taking a child directly from his parents provides better opportunities for: (1) knowing both child and parents; (2) getting along with the parents and the child; (3) inducing the parents to take more responsibility for the child. There was some secondary but direct criticism of agency standards and procedures. Most of these interviewees questioned the wisdom of an agency's interfering with the rearing of a child, and expressed doubt about whether the agency really knew the child and what was important to him. Such doubts indicated a lack of knowledge, not only of the agency's role but also of its responsibilities.

A few excerpts from the interviews throw light on some of the issues:

> For my own, I want to know the family, not the little bit that someone tells me. I want to know what I am getting into.
>
> I'd rather go see them (the social worker). It would seem less like they're checking up on me.
>
> The social worker shouldn't visit without the consent of the parents.
>
> From what I hear from other people, they upset you. Why did you do this? Why did you do that? They don't give you enough to really take care of the child. So why be bothered with an agency too?

Similar attitudes were displayed when we asked what advice the interviewees would give a friend who needed to place his child. However, only 39 percent of all said they would recommend agency placement, although 52 percent said they themselves would prefer to board for an agency. Both groups gave a similar reason: the agency would know what is best for the child and would investigate the home.

The people who would recommend to the friend that he find a home on his own initiative raised questions about the role of the agency. They seemed not so much to dislike agencies as to regard them as third parties intruding in the relationship of the parents and the foster parents. The reasons they gave for recommending that the child be placed independently were that the friend would have (1) a more personal relationship with the child and the foster family; (2) a better chance to know the quality of the foster parents; (3) better care for his child by someone of his own choice; (4) an easier time in placing the child and getting him back; and (5) more trust in the foster parents.

Some of these reasons were expressed in the following ways:

> It is not good for a child to be shifted from one foster home to another.
>
> It is better to have the child with someone you know or can get to know rather than with strangers.
>
> The parents should see for themselves where the child is going.
>
> The parents would be better satisfied; the home they choose would not be like the homes used by welfare agencies.

Such comments pose a question that is sometimes overlooked. Does caring for someone else's child make a person a "foster" parent? Or does it, in the eyes of the public, merely provide child care for the parents, who do not thereby lose parental status? The Child Welfare League of America has recognized this difference in one of its documents:

> Adding, no doubt, to the confusion of roles is the myth that these people are foster parents. They well may have been so when most children in foster care were either orphaned or abandoned, but it can hardly be sustained in face of active parental involvement in the case of the child's natural parents, their participation in planning and often financing of his care, and their visits with him in the foster home. Clearly, if these are his parents, then the foster parents are not, yet we persist in calling them foster parents and in selecting them as if they were that to some extent.[2]

Attitudes of Negroes

Many of the findings of the survey have implications concerning the social role of the agency and concerning cultural factors in the problem of foster home recruitment. Indirect evidence of this was revealed in the data obtained from Negroes.

Fewer Negroes than whites knew people who had boarded children. This was understandable in view of the great immigration of Negro families to the city in recent years. Many of the Negroes we interviewed indicated that they did not consider taking care of a friend's or relative's child, often without pay, as "boarding". The problem of recruitment of Negro homes, or at least one facet of it, must be viewed with the knowledge that the Negro community is carrying out some of the child care task spontaneously.

Although only about 50 percent of the Negroes interviewed had known someone who had boarded a child, more of them than the white interviewees had talked to foster parents about their experiences in boarding a child. They too regarded foster children as little different from others. Yet they tended not to be interested in boarding children themselves.

Generally, however, the Negroes had a favorable attitude toward the agencies. Almost twice as many Negroes as whites would recommend agency placement to a friend. They stressed the facts that the agency knows what is best for the child and is able to assume financial responsibility. On the other hand, more Negroes than whites were hesitant about ever wanting to board a child for an agency. This uncertainty seemed to be rooted in lack of knowledge rather than in negative attitudes toward children or the agencies.

Eight percent of the Negroes said they did not know of a social agency to which they might refer a friend who needed to place his child, compared with 3 percent of the white people interviewed. Furthermore, 15 percent—almost twice the proportion of whites—did not know whether agencies paid board for children. The Negroes also tended to be less well-informed than the white interviewees about the agencies' needs. Nearly one-fourth—twice as many as the whites—thought that agencies would not have difficulty finding foster homes for children.

However, about the same proportion of each race had heard or seen agency publicity on the need for homes. The Negroes more often had been reached by radio and television and the whites by newspaper publicity and talks before groups such as parent-teacher's or church associations. But the Negroes tended to remember fewer of the details of the publicity. On the other hand, over twice as many Negroes as whites said they thought their PTA, church, or club would like to hear more about children needing foster homes. Whether or not this was the kind of sincere interest that would produce foster homes or mere friendliness could not be determined. Nevertheless, this expression of good will, viewed in the context of the general lack of information, produces a challenge to reach Negroes at the grass roots, in their primary groups.

Another significant attitude among Negro interviewees was that if they were to be paid at all for boarding children they ought to be paid well. Generally they reacted much more negatively than the whites to the current board rates for foster care. Faced with economic realities, and given an alternative, the majority of Negro interviewees apparently would choose that which produced the higher income. This raises the question of whether higher board rates, geared more specifically to the recruitment of Negro homes, would bring results.

In spite of some differences in degree between the races and between the neighborhoods, one common thread ran throughout the interviews: a general fund of misinformation and lack of information about agency programs and the role of the agency in child placement. Slightly less than half of the people interviewed had seen or heard any publicity about the need for homes.

From this it would appear that spot announcements in the mass media of communication and other agency publicity are not effective in making people want to board children and are not correcting misinformation. The people with the least knowledge about foster care thought that such things as low board payments, visits by the social worker, or disapproval by friends would deter them from becoming foster parents.

Increasing knowledge and understanding, therefore, is of crucial importance to recruitment. It is a prerequisite to a more favorable attitude toward foster care itself and to influencing otherwise positively motivated families to take the initial step toward foster parenthood.

On the other hand, the survey also gave many hopeful clues to recruitment. A sizeable proportion of the interviewees indicated that they thought their club, parent-teacher's association, or church group might like to hear more about the needs of foster children. Meetings with groups at the "grass roots" should provide the opportunity to interest people in boarding children and to correct misinformation. Methods learned from working with the "hard to reach" families, such as holding first interviews in the home, might well be adapted to this purpose.

Also significant for recruitment planning was the finding that people who had known foster parents knew little about the agency's role. There was the inference that the use of the impersonal agency in some way removed the child and the foster parents still further from the child's own parents. Apparently agencies cannot take for granted that foster parents themselves understand, let alone can interpret, what an agency is trying to achieve. In the realm of interpretation as in other areas, foster homes are only as good as an agency makes them. The need for a specific, if not formalized, training program for foster parents is implied.

In conclusion, the survey in all its aspects points up the need for focusing attention on the content as well as the direction of foster home recruitment programs.

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[1] Maas, Henry S.; Engler, Richard E.: Children in need of parents. Columbia University Press, New York, 1959.

[2] Wolins, Martin: Proposed research program for the Child Welfare League of America. Child Welfare League of America, New York, 1959.

CONFLICTS IN PROTECTING THE NEWBORN IN HOSPITALS

MARGARET W. THOMAS
Nursing Consultant, Division of Health Services, Children's Bureau

IT IS A WELL documented fact that staphylococcal infection is no stranger to hospital nurseries for the newborn.[1,2,3] The number of reported epidemics in which mothers and newborn infants have been involved, contrasted with the number reported among other hospital populations, seems to indicate that infants are the most susceptible group. But, many people, especially infants, acquire staphylococci, including epidemic, antibiotic resistant strains, without showing signs of actual infection—in other words they have become "colonized" by the organisms. The extent to which infants and mothers who become colonized with these strains in the hospital spread infection among other members of their families after hospital discharge has not been thoroughly investigated. However, Ravenholt [4] emphasized the important role of hospital nurseries and infected infants in the dissemination of staphylococcal disease to the community, and Wentworth [5] finds the hospital nursery to be a source of family infections.

In all of these investigations, the accusing finger points to the hospital as the environment from which the problem originates. It is speculated, but not yet substantiated, that the recent increases in infant mortality may, to some degree, have their roots in staphylococcal infections. The 53 percent increase in the rate of infant deaths from "other infections of the newborn" and the 48 percent increase in infant deaths from septicemia and pyemia, which occurred in the United States between the periods 1950–1953 and 1954–1957,[6] have not been examined minutely to determine what is known of the etiologic infecting agents. Hospital personnel, naturally concerned about the health and lives of persons entrusted to their care, and desirous of removing the onus of careless practice, have sought to place every conceivable roadblock in the path of the offending organisms. This has resulted in extensive changes in policy without, in many instances, thoughtful consideration or careful investigation into whether the new policy is, in truth, more of a safeguard than the one it replaces.

Running parallel to the concern about staphylococcal infections is the concern of a large group of professional workers that care be geared to the psychological as well as the physical needs of mothers and infants. This, too, has resulted in changes in policies over the last 10 or 15 years in some of the more philosophically progressive hospitals. The dilemma now is that the policies relating to the control of infection are often the diametric opposite of those directed toward strengthening psychological components of care. Thoughtful professional people are asking which objectives could or must be sacrificed—which values shall be held.

Conflicting Philosophies

In order to facilitate presentation of various views, we will designate the exponents as the BES group and the PAC group. The BES group is made up of bacteriology, epidemiology, sterility-minded individuals who are on the side of stringent aseptically-safe-at-all-cost policies. The PAC group (psychological aspects of care) is made up of many specialists in maternal and child health, mental health specialists, and some concerned people who are just plain kindhearted. This group struggles to hold onto its long-fought-for gains and demands scientific proof of a need for relinquishing them.

The BES group contends that traffic in the labor-delivery suite must be kept at a minimum, that therefore husbands should not be allowed in this area. The PAC group argues that when a woman is in labor it is important for her husband to be there.

The strength in the BES contention lies in studies such as the one by Blowers and associates [7] in which the general bacterial count of air in an operating room increased substantially during periods of increased activity; and the study by Byrne and Okeke [8] demonstrating increased expulsion of bacteria from nose and mouth during coughing, sneezing, loud talking, laughter and heavy breathing.

The PAC group counters by referring to studies by Middleton [9] and Wolf [10] which indicate that air is of little significance in the spread of staphylococcal infection. Its members maintain that most of the published studies on hospital air contamination have been related to the risk of surgical wound infections and not to infections of the parturient woman and her newborn baby. They further argue that the psychological values of having the husband and wife together, if this is their desire, should not be forfeited on such inconclusive evidence. And they add, sometimes caustically, that since so many people are in and out of the labor suite anyway a few fathers should not significantly add to the hazard.

The same arguments are used in regard to the policy of allowing members of expectant parent classes to tour the obstetric department, including the labor-delivery suite. The BES group would eliminate tours; the PAC's would retain them but agree to certain modification in the procedure.

The values of both groups might be held by allowing husbands in the labor unit but providing safeguards against their possible contaminating influence. Soap and water handwashes and the use of protective gowns would be required even though the value of protective gowns has not been proven. The husbands should have explained to them the need to take all necessary precaution and therefore to admit honestly any symptoms of infection which would automatically eliminate them as candidates for admission to the unit.

Possible solutions to the problem of parent tours has been suggested by Rakich, Thomas, and Lester.[11] These include stopping the tour short of entrance to the delivery room, thorough cleaning of the delivery room following the tour, or substitution of colored slides or films of the unit for the actual tour

On two issues the opposing groups came fairly close together. The establishment of policies regarding visiting hours has long been considered by standard-makers important as a means of minimizing the possibility of infection in mothers and infants.[12, 13] Members of the PAC group, on the whole have attempted to limit new mother's visitors to the husband and the baby's grandparents and to not more than two visitors at a time. Children under 12 have been refused admission on the grounds that communicable disease and respiratory infections are common among them. The BES group hopes to maintain the status quo; not enough PACers question the policy to cause a serious conflict.

The major problem is in small and rural communities where visiting persons in hospitals is considered a social affair and a moral responsibility. Hospital authorities in such areas often believe they will incur the wrath of their public if they are militant in enforcing visitor regulations. Conceivably, however, the public would be understanding if time were devoted to explaining a new mother's need for rest and the need of both mother and baby for protection from possible exposure to infection. While epidemics have yet to be proven the result of extensive visiting, there are also no facts with which to contradict the logic of limiting visitors.

The other issue about which there seems to be more agreement than conflict involves the advisability of having the baby in the same room with the mother rather than in a central nursery. The members of the PAC group are apt to be proponents of rooming-in as a means of keeping the family unit intact and of helping new mothers learn to know and care for their infants while they have professional supervision and guidance. They are pleased that some members of the BES group believe that rooming-in would reduce the risk of cross infection below that prevailing in central nurseries.

Breast Feeding

A BES-recommended policy causing alarm among the PACers is that all breast feeding be discouraged. The extent to which this policy is advocated is unknown, but it has been reported to this writer—who spent a year working with nurses on staphylococcal infection control—a sufficient number of times to lead to the conclusion that it needs study.

The basis for the policy lies in studies such as those by Shaffer,[2] Wentworth,[5] and Wysham [14] in which it was found that puerperal breast abscess occurred in practically every staphylococcal epidemic. In some instances the incidence reached the level of 10 percent of all postpartum women, or 30 percent of those who nursed their infants. Wysham observed 117 mothers during an epidemic, 9 of whom developed breast infections. These occurred only in mothers who nursed their infants and whose infants were colonized with the epidemic strain.

The PAC philosophy embraces encouragement of breast feeding, if the mother's physical and emotional conditions allow it. The members of this group question whether there is sufficient evidence to warrant wholesale abandonment of breast feeding when no epidemic has arisen and would go so far as to suggest that mothers who wish to nurse their infants may do so with relative safety if their infants have not become colonized with staphylococci or have become colonized only with non-epidemic strains. They would suggest trying rooming-in as a means of minimizing colonization and studying the effectiveness of this procedure. They would further study the mechanism by which the infant infects the mother, attempting to learn whether the condition of the breast is an important factor and, if so, what is necessary to keep breast tissue healthy. They believe that breast feeding has physical and psychological advantages to both mother and infant in many instances, and therefore they would relinquish it only as a last resort.

When To Discharge

In order to minimize the risk of newborn infants becoming colonized with staphylococci, BES policy would favor early discharge from the hospital. The PAC group would weigh the results of the risk of colonization against other risks inherent in early discharges. For years they have done this in relation to the tendency to discharge patients early as a result of the practice of early ambulation and of rising costs of hospital care.

The chances of the newborn infant's becoming colonized with staphylococci increases with the length of hospital stay, even where no epidemic exists. The greater the number of colonized infants, the greater the possibility not only of overt staphylococcal disease in the infants themselves but in other members of the households to which they return from the hospital.

The degree to which colonization occurs varies extensively from hospital to hospital. Hurst [15] found that 77 percent of infants in a hospital were colonized at one or more sites by the fourth day after birth. In another hospital, investigated in the same study, the rates were only 3 percent and 16 percent on the first and fourth days, respectively. According to Wolf,[10] Baldwin reports 30 percent on the sixth day, and Cunliffe found 20 percent by the end of 48 hours and 96 percent by the sixth day. Fekety [16] found 17 percent colonization of the anterior nares on discharge, on the third or fourth day.

The factors which characterize hospitals with low or high colonization rates have not been identified sufficiently to point the way to a guarantee of low incidence. When this is done the day of desirable discharge can be determined after consideration of all the needs of both mothers and infants, and not just of infection risk alone.

Another unanswered question is, of all infants who become colonized with the organism, how many actually acquire staphylococcal disease? Shaffer [2] reports a morbidity rate as high as 50 percent in five widely separated localities, and as low as 1 percent in others. In these situations, the recognized epidemic strains of staphylococci were involved. Hurst [15] found 27 strains and 10 combinations of strains in one hospital and demonstrated their variable capacity for colonization and their infectivity.

Looking at this array of facts with their variables and uncertainties, the PAC group admits that there may be some validity to a policy of early discharge even though there is no specific point of protection—short of no hospital admission at all—and even though no one really knows how many mothers or infants can be protected from what hazard by such a policy. However, they warn of some dangers in sending a mother and new infant home—where medical and nursing supervision are remote—within 12,

A device for the newborn created with psychological needs in mind is the drawer-like bassinet in which this baby lies. A glass wall separates the mother from the nursery but she can pull her baby into her own room whenever she desires.

24, or 48 hours of the child's birth, without adequate planning for safeguarding the health of either. They also point out that, in many instances, return home means for the mother a return to household responsibilities for which she is not ready. They acknowledge that they are not in a position to prove that early discharge is harmful since the conceivable untoward results have not been studied.

Those members of the PAC group who are in public health tell feelingly of problems of physical, social, and emotional adjustment of many mothers who have been discharged early. They believe that early discharge must be accompanied by medical care provided in a fashion that does not require the 3-day postpartal mother not only to find substitute care for her other children, but also to find transportation (perhaps a taxi she cannot afford) and to sit for hours in a clinic or in a physician's office. They want to see her provided with home help so that she will not have to be concerned with laundry, house cleaning, food purchasing, getting the other children ready for school, and the like, a few days after she has given birth. They want arrangements made for a public health nurse to visit the family several times in the first week to observe the mother's and infant's progress, as the physician and nurse would have done in the hospital.

About Procedures

The environmentalists—persons who are inclined to believe that environmental rather than human factors are of primary importance in the spread of infection—are members of the BES group. They are the persons who spend hours devising more and more elaborate systems of keeping things clean, almost to the point of sterility. The procedures they develop require untold time, some of which is their own but much of which is someone else's. When these procedures are of a housekeeping nature and the housekeeping department has sufficient staff to carry them out, all is well. But when they are of a housekeeping nature and fall on the professional nursing staff, a conflict in responsibilities arises.

PAC nurses have been taught and believe that although cleanliness is essential, so is it essential to have time to observe patients, attend to acute needs, learn why an infant is crying, help a mother to nurse her infant, listen to her problems, and answer her questions. These nurses feel frustrated when they cannot do all of these things and must set up a system of priorities without sufficient understanding of the significance of the elaborate procedures.

The solution to this problem is to keep procedures as simple as is consistent with known scientific facts and to explain these facts to the staff. When there is still speculation, as there is in many instances, procedures should favor the side of safety but additional and suitable staff should be provided.

A resolution of the differences in the philosophies of care outlined in this article must be made if policies in maternity care are to be established which take into consideration both the physical and psychological needs of mothers and infants. This will only be done if there is provision for airing these philosophies, a plan for research to get at the truths underlying them, and a willingness to give and take.

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[1] Williams, R. E. O.: Epidemic staphylococci. *The Lancet*, January 24, 1959.

[2] Shaffer, Thomas E., et al.: Staphylococcal infections in newborn infants. II. Report of 19 epidemics caused by an identical strain of *Staphylococcus pyogenes*. *American Journal of Public Health*, August 1957.

[3] Lester, Mary: An annotated bibliography. *American Journal of Nursing*, December 1959.

[4] Ravenholt, R. T.; LaVeck, G. D.: Staphylococcal disease—An obstetric, pediatric, and community problem. *American Journal of Public Health*, October 1956.

[5] Wentworth, Frederick H., et al.: Observations relative to the nature and control of epidemic stayphylococcal disease. *American Journal of Public Health*, March 1958.

[5] Chenoweth, A.; Hunt, E.: Current trends in infant mortality. *Children*, November–December 1960.

[7] Blowers, R.; Mason, G. A.; Wallace, K. R.; Walton, M.: Control of wound infection in a thoracic surgery unit. *The Lancet*, October 15, 1955.

[8] Byrne, John J.; Okeke, Niegha E.: Surgical wound infections. *American Journal of Surgery*, September 1957.

[9] Middleton, R. W. D.: Wound infections. *Medical Journal* (Australia), March 28, 1959.

[10] Wolf, Harold W., et al.: *Staphylococcus aureus* in air of an operating room. *Journal of the American Medical Association*, April 25, 1959.

[11] Rakich, Jennie H.; Thomas, Margaret W.; Lester, Mary R.: Nurses are asking about staphylococcal infections in the obstetric department. *American Journal of Nursing*, November 1960.

[12] U.S. Department of Labor, Children's Bureau: Standards and recommendations for hospital care of maternity patients, 1946. (Out of print.)

[13] American College of Obstetricians and Gynecologists: Manual of standards in obstetric and gynecologic practice. Chicago, 1959.

[14] Wysham, Donald N., et al.: Staphylococcal infections in an obstetric unit. II. Epidemiologic studies of puerperal mastitis. *New England Journal of Medicine*, August 15, 1957.

[15] Hurst, Valerie: Transmission of hospital staphylococci among newborn infants; II. Colonization of the skin and mucous membranes of the infants. *Pediatrics*, February 1960.

[16] Fekety, F. R., et al.: Control of an outbreak of staphylococcal infection among mothers and infants in a suburban hospital. *American Journal of Public Health.*, March 1958.

In Connecticut, beginning a new life for delinquent girls means . . .

BRINGING TRAINING SCHOOL AND COMMUNITY TOGETHER

ETHEL D. MECUM
Superintendent, Long Lane School, Middletown, Conn.

TRAINING SCHOOL personnel have long deplored the public's lack of understanding of the tremendous needs for community acceptance of the children committed to their care, both while they are in the institution and after they return. The public sighs over the reports of increased juvenile delinquency and is relieved to have particularly annoying youngsters removed from the community. But seldom do the people of a community assume any real responsibility for what is happening to these young people until they return to town again—unless some drastic situation, such as an escape, brings it into the limelight.

Too long we "institution folk" have accepted this lack of understanding and communication as inevitable, feeling too busy doing the job at hand to do much about public relations. Unless we take the time to point it out, the public is not going to know that the philosophy of the training school has changed from the old "reform school" idea of custody, punishment, and vocational training to one in which all activities and planning are directed towards helping the young person to be ready to return to community life in a relatively short time and to help him live there in a socially acceptable manner.

The training schools, unfortunately, have been far slower than the mental hospitals and schools for retarded children, in availing themselves of the opportunities to extend and enrich their programs through the use of volunteers and community facilities, and in so doing to gain community interest and support. Some administrators are loath to attempt such programs because of the hazards involved.

Since a State training school, unlike a private institution, cannot select or limit its intake, it may well become a sort of "catchall" for children with a wide range of age, intelligence, ability, and type of problem. However, as we pay more attention to individual needs we discover that while no two youngsters are exactly alike, most of a training school's population has much in common. These young people, who have known much rejection and have backgrounds of overwhelming family and personal problems, are nonconforming, "rootless," disillusioned by life experiences, and confused in their values. Usually they have moved often, disliked school, and experienced deprivation. They have become accustomed to punishment but have had little consistent discipline. They have not learned how to work or play or to face reality. They have grown up in an impersonal sort of world and have learned either to strike back at it with hostility or to withdraw into themselves to nurse their festering wounds.

The training school must offer such young people controls, protection, training, individual guidance, and education in what is sometimes called a "therapeutic community"—a group-living situation where young people can learn gradually to get along with adults as well as with their peers in a relationship of mutual respect. In such an atmosphere, they may begin to gain the needed hope, confidence, and trust which will enable them to respond to the interest and concern of people around them. The staff has to realize that they are hard to reach and need a great deal of assistance in meeting standards and that some of them may fail completely.

Generally it takes a combination of factors to transform these young "social misfits" into good citizens while they are in the school: cottage life; educational programs; recreation; religious participation; extracurricular activities; good physical care; consistent and reasonable discipline; counseling; psychiatric and psychological consultation; the maturing experience which comes from successfully completing a task; the sportsmanship learned from play; help in planning for the future; finding someone who believes in them. But what happens when the young person leaves the comparative security he has found for life in a community where he may be ignored or frankly told he is unwanted, or, even in spite of the best of community intentions, otherwise made to feel "different"?

A recent study of self-esteem done at Long Lane School, a State training school for girls in Connecticut, in cooperation with Wesleyan University psychology students, has shown that newly admitted students to Long Lane have much lower self-esteem and a much higher rate of anxiety than a high-school control group in the nearby community. Our experience at the school has shown, however, that as students experience success in various ways and gain acceptance during their institutional stay, their self-esteem rises and their anxiety decreases. But we have also found that as the time for placement grows near, anxiety increases. At such times many young people show signs of increased nervousness and irritability. Sometimes they run away or behave badly in other ways in an effort, perhaps, to insure a longer stay in the institution without losing face with their peers for their weakness in *wanting* to remain. When the time to leave approaches, many young people express fear of rejection by the "outside world."

Members of the Long Lane Tri-Hi-Y Club participated with other Tri-Hi-Y girls in this fashion show at a town theater.

Long Lane School, a modern cottage-type, "open" institution, is advantageously located in a small city in the center of a small State. Student participation in planning activities has for many years been part of its program. Visitors have been welcome. Before 1955, when we began a special effort to bring the girls closer to the community, interest groups or "clubs" for the students had been started periodically but without eliciting much student interest. The girls had not belonged to clubs "on the outside" except for the gang affiliations which we wanted to discourage. They were not comfortable on the occasions when they met the public and, much as they talked about that great day when they would be "going out," there was real anxiety about how they would fit in and how people would feel about them.

Too many youngsters who seemed to be making excellent academic progress in our school and who seemed to have realistic goals for the future failed to make the grade in a regular public school when they returned to the community. Too often, too, the girl who had developed good work habits in the institution failed to secure or keep employment. Youngsters who had seemed to find comfort and inspiration through religion failed to attend church after leaving the institution. Girls who had shown leadership ability and capacity for success in the school, where there was less competition, became floundering and hopeless again back in the community. Their quick discouragement sent them back to the "old crowd" and into conflict with the law and eventually back to the institution.

Concerned with these evidences of failure we realized we needed somehow to provide a way in which the girls could develop greater self-confidence, greater awareness of their abilities, greater ambition—while they were with us.

We saw that the ultimate end of our job was to teach young people how to live acceptably and happily as contributing members of the community—strong enough to live with the inevitable frustrations, trusting enough to use community resources. This could not be done without much community help. We also saw that community help could not be secured until the people of the community had greater knowledge of the needs of the girls in the institution—and how we hoped to meet them. Toward these ends, we planned a definite "campaign" which is still being carried out.

As part of this campaign the staff took every opportunity to tell community groups about the school's point of view and objectives and of the girls' needs. We spoke at many meetings of parent-teacher's associations, church and civic groups, service clubs, sociology classes, and the like. Some of these groups invited us merely to fill up the year's program, but many developed a real interest in what we had to say and followed up our talks with visits to the school and the adoption of various projects ranging from financial contributions and "big sister" arrangements to working toward State legislation affecting the institution. We also encouraged organizations to use our facilities for their meetings—United Churchwomen, Girl Scout leaders, the local garden club (which used our greenhouse), a little theatre group (which used the stage), the service clubs, and social work organizations. This introduced us to many people who might otherwise have stood aloof from us.

Student Planning

As the community developed more acceptance of the institution, we made efforts to help the youngsters begin to feel part of the larger community and to develop some sense of responsibility to it.

The first step was a student planning group, known as the Saturday Forum—a self-perpetuating committee, with membership from each cottage. In weekly meetings with the superintendent these students discussed whatever was uppermost in their minds and hearts. The group eventually took on the character of a service club, elected officers, followed parliamentary procedure, and planned programs, often choosing "outside" guests appropriate for the discussion topic of the day.

A minister, a priest, and a rabbi came when religious differences were bothering the girls, and great seemed the amazement and relief of the group when they found that these men could be good friends in spite of their different doctrines. A local police officer was invited because "most of the kids hate cops." His quick sense of humor and ability to understand their resentment towards "the law" helped them to decide that at least some policemen were human. A newspaper reporter was invited because the papers "just play up all the bad things teenagers do—never bother to print anything good about us." He afterwards said he was surprised to find how different these girls were from his mental picture of "juvenile delinquents," and his paper carried an editorial about the joy our choral group had brought to people during the Christmas season. A student from the men's college nearby entered wholeheartedly into discussion of how hard it is to stand up for what you know is right when "the other kids call you chicken." The girls seemed to find comfort in knowing that even college men have to meet such situations.

Girl Scouts from the Long Lane School are congratulated by the county Scout executive and a Mariner Scout from the nearby community on receiving their five-point pins.

At the request of the forum, one of its members now meets each new student on arrival, and helps the social worker to interpret the institution's program and show the newcomer around the campus. ("New kids don't believe what the staff tell 'em but they might get off to a better start if we could talk with them before the wrong girls get hold of them.") The forum has sponsored the institution's exhibit at the county fair, planning and arranging the display along with students from other schools in the area. It has also met with representatives of other schools and youth groups for joint planning of a talent show and games.

It has been heartening to watch the interaction of the members of this group, the frankness with which problems are attacked, the growth of self-confidence and poise, and the satisfaction which comes to the members with each successful venture. As with any organization, the forum has also had its discouraging times. There is always a general feeling of letdown when a member is unable to accept the responsibility given her.

Former members who have "gone out" are particularly welcome guests at the forum and are plied with questions. Usually someone will remark, "If she could do it, maybe I can, too." Our girls are more afraid of being looked down on or made fun of by their own age group when they leave the school than they are of adult rejection. This makes many released girls seek out the old gang.

Club Groups

Adolescents being natural "joiners," the number of informal "underground" groups with antisocial aims within the institution made us anxious to see whether the motivation and value system could be changed by the introduction of acceptable clubs with community counterparts. We invited the leader of a flourishing community Y-teens club to come and tell us about it. Our girls were polite but obviously uninterested. Too late we realized our approach had been all wrong. This was obviously something we adults felt would be good for students—like vegetables, and medicine and education—and institutionalization!

The next inspiration—a 4–H Club—grew out of the suggestion of one of the youngsters and we gave her full support in organizing it. This club has taken part in city and county activities with other 4–H Clubs—dress revues, favorite food shows, county achievement meetings, talent shows, leader banquets, a 4–H auction, 4–H fairs, 4–H bus trips. Some of our members have gone to the 4–H camp each year. One girl won the good camper award.

Our Girl Scout troop, now a senior troop, started out enthusiastically, with the blessing of the local Girl Scout office, excellent leadership, and uniforms paid for by the local Kiwanis Club. The members' pride in those uniforms died suddenly when other girls began to refer to them as "fruity" and the Scouts were torn between loyalty to a popular leader and desire for acceptance by their hecklers. However, as they began taking part in Scout activities with other troops and found acceptance from the girls in them, they began to see Scouting (even the uniform) as something of which they could be proud. The troop has taken part in the court of awards, overnight camping trips, and service projects. Each year four or five girls have spent a 2-week period at the Scout camp, camperships having been provided by a community service club. Two or three of our former Scouts, now living outside the institution on job placements, have gone back to the camp for two summers to help the camp staff.

The Tri-Hi-Y Club, connected with the local YMCA, is led by the director of the Y's girls' department. Under her leadership the girls have undertaken a particularly ambitious program: lectures, hikes, parties, service projects, participation with other Tri-Hi-Y Clubs in basketball games, parties, a mother-daughter banquet, the "Y" area youth and government program, a beauty workshop, and a fashion show and a money-raising circus. The president of the club attends the monthly planning meetings at the "Y" with the other presidents.

The Catholic Sodality meets regularly under adult leadership with several city high-school members of the Catholic youth organization. Our girls are impressed by the sincerity and friendship of these young women who so obviously are not ashamed to live with their religion. Several of the friendships between girls from the institution and outsiders which have developed in this group have continued after our girls have left the school. They have been invaluable during the transition period of adjusting to community life when a girl most needs something to do with her leisure time.

Junior Garden Club, sponsored by the Women's Garden Club of the nearby city which furnishes the leaders, is a favorite group for girls interested in flowers and nature study. The girls make flower arrangements, table decorations, indoor gardens, and corsages, take trips to flower shows, and have an exhibit at the Garden Club Fair, thus having a chance to exert their creative abilities.

The Acrobatics Club appeals to the more athletically inclined and offers a wholesome channel for surplus energy. The leader is a teacher of dancing and acrobatics from a nearby town.

Membership in the Cady-Wesleyan Forum is eagerly sought. This is a small group of 11th and 12th grade girls and a carefully selected group of young men from the university. Weekly after-school meetings devoted to discussion of subjects from "dating" to "What is happening to the youth in Russia" give way occasionally to social meetings at which the girls demonstrate what good cooks and hostesses they are. This group has as an adviser a member of the school faculty and as a moderator a senior student from the university who shares the responsibility for program planning.

Values and Problems

These and other clubs are now a well established part of life at Long Lane School. Every student has the opportunity to sign up for membership in a club of her choice. Most clubs have waiting lists, membership requirements, and rules. Every club and extracurricular activity has been given a point value, and no one student may carry more than a certain number of points.

Since the success of a club depends to a considerable extent on its leadership, every effort has been made to find just the right people in the community to serve as volunteer leaders. We have found that the most successful leaders are enthusiastic, personable, tolerant, and possessed of a goodly amount of that mysterious something called leadership and the ability to establish a warm, friendly relationship with the girls. Before each leader has begun her task, she has been helped to become familiar with the institution and its overall program, to know what the girls could and could not be permitted to do, and to feel free to come to the staff for help and advice when needed. Club leaders often play an important role in the girls' life. They are more easily accepted than staff members because they do not represent the "authority" of the institution.

We have found the following values in clubs:

1. They offer the girls an escape from the institutional "routine".
2. The new interests they bring dispel a sense of aimlessness.
3. They produce natural groupings which can be molded constructively by the adult leader.
4. In inducing a desire to belong they provide an incentive for girls to change their behavior pattern enough to be acceptable to the club group.
5. They support acceptable standards and tend to raise the standards of many individuals who could not change without group support.
6. They offer the girls opportunities for success and recognition, thus nurturing the development of self-confidence.
7. They bring the girls opportunities to gain acceptance from other persons of their own age group who belong to counterpart clubs in the community.
8. They bring their members experiences in good citizenship through voting procedures and fund-raising activities for their treasuries and for various community causes such as the United Fund or a hospital building.
9. Through bringing the girls new and healthy friendships with club leaders and sponsors, they help them establish better relationships with adults in general.
10. They help the girls develop specific skills.
11. Their various activities help the girls to develop social and civic competence, broadened interests, increased self-confidence, and individual status.
12. Their leaders become good-will emissaries for the school.
13. They bring some members the opportunity to transfer, with help from their leader, to similar clubs in the community when they leave the school.

On the negative side, the clubs bring some problems:

1. Interruption of the institution's routine.
2. The tendency on the part of club leaders to become discouraged when members, teased by their peers about their club interest, drop out, do not participate in meetings, or subject the leaders to severe testing.
3. An occasional lack of understanding between some club leaders and some staff members, especially in the beginning—promoted by youngsters quite accustomed to playing adults against one another.
4. The creation of a desire on the part of club members for more clothes and more spending money to help them "live up to the Joneses" as they participate in community activities.
5. A waning interest in cottage and school projects as more time and interest is given to club affairs.
6. Much additional work for staff—endless arrangements to be made, notices to be sent, preparation of materials for club meetings, arrangements for transportation, conference and planning sessions with club leaders.

For the Non-Joiners

Of course not all girls take advantage of club membership, and some who do join drop out or are dropped by our club. For the individual who is not a "joiner" or not yet ready for this kind of activity, the institution's program offers other, less threatening opportunities to come in contact with the community: field trips in connection with school classes; membership in baton twirling or choral groups, or athletic teams; special "outings" to places of historic interest; and activities such as roller skating and bowling, in community facilities. Sunday school teachers and other volunteers from the community occasionally take members of their classes to their homes for dinner and to special church services, plan Sunday school parties and picnics and accept invitations to the girls' cottages for supper or an evening party. Other neighbors also invite one or more girls to attend church services with them in the community and sometimes take them to their homes for dinner.

A few girls have joined Sunday school classes and young people's groups in churches in the nearby towns, transportation being provided by church members. One girl helped out for a month at a day camp for Brownie Scouts. Another acted as baby-sitter at the YMCA during a gymnasium class for mothers. Two others work a few hours a week at a nearby convent retreat house. Some girls have Saturday morning housecleaning jobs in private homes, which provide them with spending money and provide other girls with an incentive to learn how to do these tasks well enough to be eligible for such jobs.

The girl who is not voted into the club of her choice or who seems a misfit is helped to choose another group better suited to her needs. Staff members attempt to discover the girl's special interests and abilities which may be developed. Sometimes a new club is born in this way. For example a leader is found to teach modern dance one evening a week in one of the cottages, or glamour aids in another.

Here too, as in any community, there are girls who enjoy the solitary pursuits—reading, knitting, doing puzzles, or attempting to write poetry. One girl with superior intelligence but no interest in campus organizations finds real satisfaction in a reading group for high school students at the city library. We must respect a girl's right to make such choice even though we assure her that there is a group activity for her at any time she chooses to exert her woman's right to change her mind.

A women's auxiliary, composed of women from the community who have become interested in the institution, has become an invaluable tool for making these opportunities for the students possible and for promoting better understanding in the community of the institution's program and problems. The members, some of whom are former staff members, meet at the school monthly. The early meetings were spent in learning about the institution from representatives of the institution's various departments—education, social service, health, cottage life, and vocational training. Although primarily a public relations group, the auxiliary has done some fund-raising to meet needs which the institution's budget cannot be stretched to cover—visual educational aids, badminton sets, electric corn poppers, magazines, prizes for the institution's annual fair. Several of its members also carry out some direct service such as taking children for appointments with eye specialists, dermatologists, and followup clinics. They also chauffeur youngsters to concerts, the circus, and other entertainments, and take the choir on its various singing trips.

Several members of the auxiliary have temporarily "adopted" youngsters whose parents and relatives never visit them. They come to see them regularly, write to them and bring them little gifts, take them to their homes for weekend visits, and in general help them to feel that there is someone who cares especially about them—someone who does not have to be shared with all the other girls.

At one meeting of the auxiliary, representatives of all of the club groups came, on invitation, for a coffee hour during which they told about their organizations and suggested ways in which the women could be of help. Women and girls alike considered this a highly successful venture. As a result, the auxiliary made it possible for the high school seniors to have a class dinner at a restaurant instead of sharing the eighth graders' picnic; and Tri-Hi-Y members invited some auxiliary members to be their "mothers" at the organization's mother-daughter banquet.

Local service clubs also are encouraged to take an interest in the girls. The Lions Club has provided money to purchase a special gift for each girl on her birthday, and a "good citizen" prize at graduation, and has made the use of a roller skating rink available to them. The men's club of a church turned its annual Christmas party into a father-daughter banquet, inviting a group of girls not included in the usual off-campus activities.

Some Results

All these activities serve the dual purpose of helping the girls to feel more comfortable in the community—and the community to see them as they are—potentially good citizens.

As persons outside the school have had the opportunity for participating in the program and have come to know it better, we have noted the following developments in the community:

1. People have been more understanding about runaway episodes.
2. Public school personnel have taken a more helpful approach to students who used to be at Long Lane.
3. The press has shown greater interest in what the institution is trying to do.
4. More opportunities have been made available to our girls for employment.
5. Legislators have expressed more concern about the school's problems.

How lasting the effects of all this will be upon the girls we serve is at this point hard to tell. We believe, however, that on the whole the girls leaving Long Lane School today have more ability for independent functioning than girls used to have at departure; and that because of this and the changes in the community they are more likely to make a good adjustment and less likely to return to an antisocial gang.

A demonstration project to protect children by restoring . . .

COHESION, DIGNITY, AND HOPE FOR MULTIPROBLEM FAMILIES

MIRIAM O. PAGE
Training Consultant, Vermont Department of Social Welfare, Montpelier

A DEMONSTRATION project to help multiproblem families achieve a better quality of home life for their children has been operating in the Vermont Department of Social Welfare since August 1959. Jointly financed by the department and the Turrell Fund of New Jersey, the project is the result of a long-time conviction of the department and the Vermont Conference of Social Welfare that adequate service to families could reduce the number of children committed to the department for foster care. The project involves the services of two full-time social caseworkers, Enna M. Bates and Barbara N. Ward, a part-time supervisor—the writer of this article—and a secretary. Originally set up in one area of the State for one year, it has since been extended to August 1961. If support can be achieved from the General Assembly, it will be continued as a regular department service in three areas of the State, and eventually throughout Vermont.

The project serves families whose children have problems severe enough to give the department, under its protective function, the right to go into homes unasked; but they are families who have enough strengths for the worker to be able to tell them honestly: "In spite of these problems we think you can and should stay together as a family." We have been careful not to call on any family until we have been sure that a serious problem exists which is affecting the children. We have, however, been liberal in our definition of "strengths," since we believe that most families can and should stay together if help is available to them.

The area in which we are operating includes nine small towns with populations ranging between 485 and 2,271, and a small city with a population of 8,500. As of October 1, 1960, we were working with 34 families having 145 children. Six of these families live in the most deprived section of the city. In this neighborhood, which includes 45 families with about 150 children, we have also been working on a neighborhood improvement project.

Individual Casework Service

In the beginning, the caseworkers visited each superintendent of schools and overseer of the poor in the area to describe the project to them and to ask if they knew of families that might be helped by it.

Of the 37 families accepted for individual casework service, 20 were referred by the public assistance and child welfare divisions of the State department of social welfare. The schools referred seven; the overseers of the poor, five. Two families themselves asked for help. The project initiated service to two families, on the basis of probation reports available to the department, and to one family living with a project family.

The manner in which these families were referred differed considerably from the way complaints had usually been made to our department—when everyone had "come to the end of their rope" and wanted the child removed immediately from the home. Those referring children to the project obviously felt that they were helping to keep families together. That they referred families about whom they might have complained at a later date is indicated not only by the problems in these families but by the fact that the child welfare division has had only one complaint of child neglect from the entire area during this period.

All the families had difficulties in relationships within the family and between the family and the community. In 25 of the 37 families there was severe economic deprivation; in 18 at least one of the parents had a serious health problem; in 14 the parents had marital problems; and in 7, one or both of the parents drank heavily. In 10 families the father was not in the home, and in 5, the mother was working. Seventeen of the families included children with school problems; 14 included children who exhibited behavior problems in the home and in the community; 8 included children with serious health needs.

In October 1960, a review of the families receiving counseling indicated that 21 of them (including the six engaged in the neighborhood project) had shown some improvement, real enough for the worker, the referring source, and the family to recognize. However, we had closed no cases except those in which the family had moved out of the area. In many instances, the situations bringing about the referral had cleared up rapidly, but the family and worker had become aware of many contributing problems on which they still needed to work. At present six cases are about ready to be closed. In these, the parents have learned something new about solving problems; have had time to test and gain confidence in their ability; and have learned to use resources within their communities.

Methods

We have profited much from material from the Family Centered Project in St. Paul, especially the casework.[1] One difference has been that we have met much less initial resistance to the service than was reported by the St. Paul project. In spite of the fact that the workers have been very direct in pointing out the problems affecting children, a few families have enthusiastically welcomed the worker at the first interview and almost all have done so after a few visits. These families have had far fewer contacts with social agencies than had the urban families in the St. Paul project and are rather intrigued with the idea that someone is interested enough to seek them out. Also, in many instances the referring source has prepared the family for the project's worker by presenting the service as likely to help. Each referring source has been willing to let the project worker use his name as she introduces herself to the family.

Fathers have shown more resistance than mothers, but we have insisted that, since they are heads of their households, the family casework service must include them. This has meant that the caseworkers have made visits in the evening as well as during weekends since some of the fathers are lumbermen who go into the woods on Monday morning and return Saturday night. In the few instances in which we could not succeed in involving the father, our help has been much less productive. The participation of disabled fathers has seemed especially important in reestablishing family morale.

Ordinarily our workers see the father and mother together, unless there is some indication of a need for individual interviews. For most of the parents, talking things over with the worker in these joint interviews is perhaps the first time they have talked things over together. The experience usually helps them to begin working out problems together even without the worker's presence.

The caseworker makes every effort to help the families relate appropriately to available community resources. These include a few social agencies, churches, schools, doctors, dentists, and recreational organizations. Few of the parents whose children were in trouble at school had ever been there to talk with the teachers or had ever attended PTA meetings. Few of the families attended church. Most of them were afraid of medical or dental care. One mother who has made amazing strides in other respects is still wondering whether she "dares" to go to a hearing clinic.

Many of these families had long felt ostracized by the community. Consequently they had sometimes acted defiantly. While there was a considerable amount of negative feeling about these families in the community, there was also concern for them and a willingness to help as soon as it was found that someone could offer suggestions and give encouragement to persons wanting to help.

Each time something has been needed by a family, the worker has not only contacted the agency able to help but has also managed to involve the family in achieving something for themselves.

A family with 14 children found it impossible to pay for the nine school lunches required each day. The overburdened mother was worn out from her efforts to feed 16 people three times a day. After the worker talked with the school principal, the school authorities agreed to give the lunches free. However, the worker also asked the parents whether there was something they could contribute from their garden. They

said they had extra cabbages. She suggested that perhaps the next year the pareots could ask the school officials what vegetables they needed and plant a section of the garden for this purpose. The worker then told the principal that the family would be offering the cabbages. These parents had never talked to anyone at the school about the school difficulties of one of their sons, but after the cabbage arrangement was worked out they and the school authorities made plans to keep in touch with each other in the boy's behalf.

Project visits are scheduled at hours most convenient for the family, whenever possible. Weekly visits are usual at the beginning, but gradually the visits are spaced at longer and longer intervals so that parents can grow confident in managing on their own. At the start of the project, the families were offered a choice of either office or home visits. Only one parent wanted to come to the office, and we have come to believe that home visits are more appropriate for this kind of service.

Neighborhood Clubs

Because of the parents' need for some recreational outlets besides the corner bar, and because we thought the agricultural extension service could impart knowledge and skills which the mothers could use, the project supervisor talked with the service's home demonstration agent about starting mothers' groups in the most deprived area of the city where four of the project families lived. While this area is composed of small, poorly built houses, with few facilities and much overcrowding, the population remains rather stable. The people seem to regard themselves as a separate community united against the "outside," although far from united in internal affairs. Public welfare expenses are high; police are frequently called to settle family and neighborhood rows; the men work only in the summertime; and a jug of wine is one of the few happy things to look forward to. One of the project workers knew nearly everyone in the community, having been there many times in the past as a child welfare worker following through on complaints of child neglect.

The home demonstration agent expressed considerable interest in working with these families, but she realized that everything would not go smoothly. We were all pleasantly suprised at the enthusiasm expressed by the five women whom the agent visited one by one to invite into the proposed club. They were to meet at the home of the R's, a project family, the only recipient of the project's casework service among the five. Because it seemed important for the families to make their own decisions about whether to join the club, the worker did not mention her part in the plan. Mrs. R told about the club and seemed pleased that the first meeting would be at her house.

On the evening of the meeting, the worker met Mr. R going home from work, gave him a ride, and at his suggestion stopped in for a moment. She found the usually dirty and unkept house sparkingly clean, and Mrs. R nervous about whether she had enough chairs and other things. The worker spent a little time trying to encourage her, leaving about 2 hours before the meeting was to be held.

The next morning the home demonstration agent told the worker that the house was dark when she arrived 5 minutes before the scheduled time for the meeting. One of the R children said her mother had been taken to the hospital, but was vague about the details. The agent waited in the car until long past the meeting time, but no one came. She then visited two of the women who had been invited: one said she had not felt well that day; and another, that she had a sick child. Both said they would like being in a club. An inquiry to the hospital revealed that Mrs. R had not been there.

As we of the project staff talked this experience over together, we became aware of the enormity of our request of Mrs. R. Not only had she never entertained, she had never been entertained. She had had so few successes in her life that she would not have been able to face it if her neighbors had not liked her home. Mrs. R later told the worker that she had turned off the lights a few minutes before the home demonstration agent's arrival. She said she had never been so scared in her life.

We decided Mrs. R had done well to go as far as she had. We felt responsible for adding still another failure to her already long list. As we talked, we searched for any positive thing of common significance to these five women and finally came up with the project worker who was so well known in the community. We realized we had been wrong in not identifying her with the plan from the start.

A few weeks later, in October 1959, at the project worker's request, Mrs. R's stepmother invited the same five women to her house for coffee. When the worker arrived, no one but the hostess was there. All five women (including Mrs. R) came as soon as the hostess put her head out of the window and shouted that the worker had arrived. After finding out that the women really wanted a club, the worker asked what objectives they had in mind. They mentioned three:

1. They wanted to clean up their streets and make them attractive with flowers. They thought their husbands would

make window boxes, and they could exchange plant slips and start new plants indoors this winter. They did not like the way the rest of the city referred to their section.

2. They wanted to get permission from the owner of the vacant lot to clean out the junk there and make play space for their children. The children were playing in the streets and two of them had recently been hit by cars.

3. They wanted to get their names in the paper for something "good"—not just "bad" things.

The women formed the West Side Women's Club in January 1960. Although there have never been more than 10 mothers at any meeting and a few families have actively opposed the club, 35 of the 45 families in the neighborhood have been active in attaining its objectives. Some teenage girls asked to be admitted, but their mothers wanted the club as their own.

The girls were therefore helped by the worker and by the county 4-H club leader to form two 4-H clubs. Their parents first volunteered to serve as leaders, then became scared because they had never heard of 4-H before, nor had they ever led anything. The two caseworkers, therefore, assumed active leadership of the club, but the parents came to the meetings and helped. Although the 4-H county leader also helped in an advisory capacity, she could not assume direct leadership of these clubs, and we were unable to find leaders from outside the neighborhood.

At the second meeting of the women's club, husbands also asked to join, but they were not included until the spring when their talents were needed in the cleanup campaign and in other projects. The club then became the West Side Community Club. The project worker assumed responsibility for guiding the group since the home demonstration agent and the assistant county agricultural agent, who helped on special projects, could not arrange to take on the task of regular leadership. The boys began a 4-H group but leadership again was a problem. Last fall, however, the county agent agreed to be the regular leader of the boys' group.

Achievements

A year after the first meeting of the six women who began the club, their original objectives had been met along with a lot of others that would have seemed overwhelming at the start. In addition, they have had a lot of fun. Here is the record:

- *Beautifying the community.* Seven truckloads of junk were carried away by the city dumptruck which was paid for out of the club treasury. Five hundred donated tulips were planted. Window boxes appeared on many houses. Flowers were planted in front lawns and vegetable gardens in backyards. Nearly every backyard now has some play equipment and many houses have been improved.

- *Making a playground.* The club earned money for clearing the vacant lot and for buying playground equipment. This was done by holding a food sale, selling chances on a quilt, holding a pot-luck supper, and selling articles made by the members. The men made benches and stools, fixed the sandboxes, and repaired broken equipment.

Mothers volunteered for playground duty, but within a week it became apparent that they were not yet able to handle the responsibility, and the project workers had to take over. However, they continued to bring refreshments each day and to assist the workers. By the time we realized the mothers' inadequacy, the project workers were so involved in seeing that the playground did not fail that they had no time to search for supervisory help outside the neighborhood.

- *Achieving good publicity.* The caseworker talked with the newspaper editors who gave fine coverage to the activities. The first election of officers was reported on the society page of one paper. Another paper carried a story about some people in the project neighborhood who did wood carvings in a series on hobbies. As time went on, newspaper coverage of the neighborhood activities was the same as that accorded any organization in the area although pictures were used more extensively for the club stories. The assistant agent of the county farm bureau helped the families with their gardens and presented the neighborhood's efforts in this respect on several of his regular TV shows on gardening.

All this publicity has greatly helped these people to achieve a sense of pride and to feel as though they were part of the larger community.

As the neighborhood project gathered momentum, one worker was assigned full responsibility for it. The other worker carried a higher proportion of families receiving individual casework service and during the summer took responsibilty for leading a 4-H club and for some playground leadership.

Neighborhood Changes

Since the beginning of these activities, the city has reported a drop in relief costs in the neighborhood and the police have been called on less frequently to settle neighborhood rows. They report that several persons who used to be brought home with regularity from the local taverns have not been seen there lately. New foods have been introduced into family menus, as a result of the cooking practice the women had in getting ready for the food sale, of their exchange of recipes, and of their increased garden produce. Homes are cleaner. There have been no complaints of child neglect, and school authorities have commented favorably on the change in appearance and attitude of many of the children. One mother, without any suggestion by the worker, canvassed the community to get parents to take their children to the well-baby clinic, which they had previously ignored.

Today whenever someone becomes sick, neighbors rally around and try to help. Several families have returned to their churches after a long period of no attendance.

At a 4-H club picnic held in May, a minor altercation between two children suddenly spread into a neighborhood row which brought to the surface all the pent-up feelings and enmities which had temporarily been put aside. Since the president of the neighborhood club was the main figure in this, the club's very existence seemed threatened. The worker recorded:

> I dreaded to go back to the neighborhood the following day but felt that I must reassure those who are still hopeful. They expressed regret that such a thing had happened during the children's picnic, but instead of my encouraging them, they were encouraging me. They said that the community plans could still go ahead and that they would work on it under a new leader. Four people had small gifts for me in an effort to be consoling. . . . Mr. A and Mr. V argued and each declared they'd never try to work on anything together. The day following, they had apologized and started building tables and benches which they displayed proudly. . . .

The city truck was due in the neighborhood on the day following the row, and, while there were mumblings, everyone came out of his house to put his junk on the truck. The last club meeting for the season had been scheduled for that night and some dentists had been invited to speak. (Children and parents had been surprisingly enthusiastic over the dental care provided through the project!) The president said she did not want to go through with the meeting, but supposed she had to since the dentists had been asked to come. The project worker encouraged her; the meeting was held and went well.

The neighborhood did not become a cohesive community again during the summer, but all the children did come to the playground, all the mothers helped, and the 4-H clubs got through to a fine "Achievement Night" attended by most of the parents. In October 1960, club elections for another year were held. Few seemed happy at the outcome but all had so much to do in planning neighborhood Christmas parties for the children, that they got to work. One mother said to the worker, "You've been helping the 4-H girls to learn to work together. We need to learn the same thing."

The workers report that no rehearsal for 4-H Achievement Night ever took place without somebody getting mad and quitting. An excerpt from the record states:

> At a meeting of the older 4-H group, one of the younger girls [we will here call Louise] wanted to participate. We told her that she could not take part, as it was rather crowded. Louise stood in front of the house with a couple of boys shouting and throwing stones, and one of the plastic ducks on Mrs. J's lawn was broken. The girls were all for chasing Louise home. I said I would go over to her house and ask her mother to keep her home during the rest of the meeting. I said I should have done this in the beginning. We had a lesson in avoiding trouble rather than looking for it. Louise was very angry for the moment. We didn't accuse her of breaking the duck, but merely asked the mother whether Louise could play by herself so that we could rehearse. Her mother cooperated; Louise was kept in the house.
>
> The group decided that money from the treasury should be used to pay for the duck. However, on the following day, Mrs. J told us not to bother as she had been able to repair it.

The club had been told from the beginning, as had all the project's families, that the worker could give no assurance of being with them after August 1960. Its members had already had some success in petitioning the city government for a street light, so that they had decided just before the row to write to the Commissioner of Social Welfare asking for continuation of the project. While feelings were still high, the group forwarded 60 letters to the Commissioner in 1 envelope, addressed by the club member with the most flourishing handwriting. All were worded differently, but most of them carried this message: "Please leave the worker here for one more year until we have finished what we have begun." The Commissioner replied very soon saying that the Turrell Fund had agreed to support the project another year, that these letters would help him get similar services for other neighborhoods.

Analyzing what the worker has done in this community, we find most important her helping the people to work for what they wanted. She called on people in the neighborhood explaining the club's plans. She helped the president write her speeches, the secretary her reports, and the treasurer her checks. She knew persons who could help the club with its programs—a woman who could teach the women how to do home permanents, another who knew how to crochet afghans, a store in which wood carvings could be exhibited, a dentist who would talk to them, and the proprietor of a place in which a food sale could be held. She introduced the assistant county agent, the 4-H club leader, and the home demonstration agent to the neighborhood. She worked with city officials to achieve a more enlightened method of work relief, and kept them informed of progress in the neighborhood, so that they were glad to attend a pot-luck supper on St. Patrick's Day.

When a suggestion for planting tulips was made, some club members predicted that the children would run over them if they ever came through the ground.

The worker asked, "Whose children are these?" The tulips were planted and many grew to flowers. When some families complained about the distribution of Christmas baskets, the worker asked why they themselves could not provide Christmas for their children. When the club members wanted a neighborhood Christmas tree, she agreed to find a place where the men could cut the tree; furnished two strings of lights *after* the club members had managed to get others; and suggested that each family bring some light bulbs. When difficulties have occurred, she has bluntly reminded the club members that they started the clubs, that they have done in them what they wanted to do: and that they cannot blame her when things go wrong.

This worker is besieged by people who want to tell her something, want to ask her, want her to see. This usually concerns something about their own family troubles or triumphs. She discusses these problems as they are brought to her attention, but does not attempt to carry on a continuous casework relationship with each family. She has used casework skills to help individuals move into, stay in, and contribute to the group. She has made it possible for them to use many community resources and specialized facilities which they knew nothing about and could not use without continued individual understanding and support.

Complementary Services

The four families in this neighborhood who have been participating in the counseling part of the project since the beginning, were all eventually drawn into the neighborhood activities. In addition, we are working individually with two families who asked for counseling help after they became involved in the neighborhood improvement program. The following example illustrates the interaction of individual casework service with the group activities:

The K's were on the point of divorce when they were referred to the project. Mr. K had several serious disabilities for which he refused treatment. He also refused to do what work he could because he feared loss of the family's ADC grant. He abused and bullied the whole household and accused his wife of extramarital sexual relationships. Mrs. K had ceased to consult him about family matters; instead she sought advice and support from other relatives. The ADC grant, though at the maximum, was inadequate to meet the family's needs.

A year after the family began to receive counseling help, Mr. and Mrs. K told the worker that the biggest change that they saw in themselves was that they now discussed family problems together and were able to function as a family unit. During the year Mr. K had taken some treatment for his disabilities; he now did odd jobs whenever he could and was talking about the possibilities of getting steady work.

The worker had begun her work with this family by talking with Mrs. K about how Mr. K might feel about his disabilities and his inability to support his family. She had then encouraged Mr. K to talk out his fears about losing the family's steady income if he got well; and had accompanied him to the clinic. She had also seen Mr. and Mrs. K together for discussion of family matters. She had made arrangements for one of their children, who was sick, to continue schoolwork at home.

Mrs. K became one of the earliest and most active members of the women's club. She obviously had fun at the meetings, participated in community improvement efforts, and sang at the pot-luck supper where city dignitaries were guests. These activities gave her a sense of accomplishment which made her better able to bear Mr. K until he could change. She began the club's garden project—in a few weeks it become "theirs"—and Mr. K was as active and proud as she. Both now talk about neighborhood needs and developments. The children have been active in the 4-H club.

Conclusion

In our work with both individual families and with groups, we use basic casework principles: we try to find out from the families themselves what they are most immediately concerned about and to help them do something about it. We feel sure that their ultimate goals and ours are the same, though our priorities are often different.

All neighborhoods do not have the same specific objectives as the neighborhood we have discussed here, but most of them, like most families, want the things which these objectives point to: self-respect growing out of accomplishment; improved opportunities for their children; a better relationship with and recognition by the community at large. No matter which of these three objectives comes first, the others will follow if the families can be helped to achieve whatever they want most. Every community has resources needed by those of its families who seem unable to cope with the problems of everyday living. But few such families will use the resources to best advantage, or even at all, unless a caseworker is at hand to reach out to them and give them the courage to go ahead.

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[1] Overton, Alice; Tinker, Katherine H., et al.: Casework notebook, Greater St. Paul Community Chest and Councils, Minn. 1957.

LEADERSHIP AND GROUP BEHAVIOR

ALFRED L. BALDWIN
Head, Department of Child Development and Family Relationships,
New York State College of Home Economics, Cornell University

IS OUR valued democratic philosophy a sound and effective one in the leadership of groups?

Some 20 years ago Ralph K. White and Ronald O. Lippitt together with the late Kurt Lewin carried out a set of classical experiments on the effect of autocratic, democratic, and laissez-faire atmospheres on the behavior of children in club groups. In a recently published book, "Autocracy and Democracy,"[1] Drs. White and Lippitt look back at the experiment to fill in heretofore unpublished details and to examine its implications in the settling of the sixties. Out of them they draw conclusions about the advantages and perils of democracy—not only for small groups of children but also for the people of a nation.

In the experiments the characteristics of democratic leadership were defined as follows: (1) all policies are decided by group discussion; (2) the leader tries to see that a clear perspective emerges in the discussion so that individuals can see how their actions lead to the group goal; (3) division of responsibility is determined by the group; (4) the bases for evaluations of individual and group activities are explained. The characteristics of autocratic leadership, on the other hand, were defined primarily as follows: (1) the leader keeps all decisions in his own hands; (2) he presents instructions to the group one step at a time so that group members cannot see the long-range consequences of the particular steps that they the taking at any moment; (3) he does not explain the bases for his praise and criticism.

When leaders carried out their assignments to be democratic or autocratic, it turned out that their behavior differed in many other respects as well. For example, the autocratic leader not only gave more orders but he much more frequently gave orders which ran counter to the wishes or the ongoing activities of the group members. He also praised and blamed individuals as individuals much more than the democratic leader. His remarks were more personal than those of the democratic leader, who was inclined to keep his evaluations impersonal and task oriented. However, the leaders did not load their autocratic leadership with negative remarks and negative criticism; in fact very little difference existed among the three types of leaders in the ratio of friendly to unfriendly remarks.

Thus the atmospheres of the three groups differed in other respects than those that were predetermined by the instructions. Whether all these features of the leader's behavior are logical consequences of the instructions or represent the leader's own interpretation of "democracy" and "autocracy" is not easy to say. In one sense this is unimportant because the study is concerned with the contrasts among the three specific types of group atmosphere described in the report. On the other hand, it is clear that these types of atmosphere cannot be taken to represent *the* democratic or *the* autocratic way of leading a group of children. Considerable variation in the specifics of group atmosphere could undoubtedly exist under the instructions given to the group leaders and, furthermore, other investigators might well have defined autocracy and democracy in somewhat different ways.

What were the results of these differences in group atmosphere upon the social interaction of the groups themselves?

The authors maintain that the democratic group atmosphere can be as "efficient" as the autocratic atmosphere. In the experiment the autocratically led groups produced quantitatively more than the democratic groups, but the democratically led groups produced adequately and their output was judged by the experimenters to have shown more creativity. There was a very clear distinction between the work-mindedness of the two groups. In one experiment within an experiment, the groups were observed while the leader was out of the room to determine how much of their motivation was dependent upon the presence of the leader. Here the democratic groups stayed on the job much more consistently than the autocratic groups.

The authors' second general finding was that an autocratic group atmosphere can lead to aggression toward the leader or toward other group members. Some of the autocratically led groups showed a highly aggressive, rather rebellious pattern, with some of the members exhibiting a great deal of hostility toward other group members. This aggression was twice focused on one scapegoat so intensely that he was driven to leave the club. However, most of the autocratically led groups showed very low levels of hostility and no overt signs of either rebellion against the leader or of aggression toward one or more of the members.

The investigators argue, however, that hostility in an autocratic group is frequently latent or hidden. An ingenious part of the experiment was the change of group atmosphere within each of the four clubs. Each group leader played each of the three roles with different clubs, and each of the clubs was for a period of time under each of the three kinds of atmosphere. Upon the day that the club shifted from an autocratic atmosphere to the democratic or laissez-faire, it was quite common to find a sudden outburst of aggressiveness. This occurred often enough to suggest that the autocratic atmosphere may have created hostility but at the same time held its expression down to a low level until the authoritarian control was lifted.

There is clear evidence also that the democratic leaders were better liked than the autocratic leaders. Only one child out of 20 in the four clubs preferred the autocratic leader to the democratic, and none of the children preferred the laissez-faire leader to the democratic.

On the basis of these and other findings, the authors conclude that democratically led groups frequently establish an attitude of good nature, kindness, work-mindedness, and a high degree of member satisfaction, while autocratic groups are more likely to be apathetic, resentful, or rebellious, and to break up readily if released from authority.

The authors recognize, however, that different personalities may work more effectively in one kind of atmosphere than in another. They describe four individual boys, two of whom worked effectively in democratic groups while the other two made life difficult for the democratic leader. They also describe a boy in one of the laissez-faire groups who because of his sense of responsibility might have taken over the leadership role and transformed the club into a democratic group if he had had a little more of the necessary skill or prestige.

The Implications

White and Lippitt attempt a detached appraisal of the strengths and weaknesses of democracy as applied in the leadership of small groups. They see its obvious advantage as the fact that it encourages group participation and is personally satisfying to its members.

As defined by these authors, democracy also provides a clear group structure, clear roles, and mechanisms of social control. However, they point out that disintegration into laissez-faire is one of the special threats to a democratic group. Such a group functions best, they conclude, when both leader and members are open minded yet realistic, self-confident yet not status minded. In a society, therefore, the development of such traits are essential for a stable democracy.

In maintaining that democratic groups can be efficient, the authors recognize that in some circumstances this may require the acceptance of a more structured control. If, for example, task efficiency is accepted by the group as the overriding requirement in contrast to individual enjoyment or self-fulfillment, then the group can accept a more structured control—one might say it can decide to encourage autocracy in its leadership for a period of time.

The total impression of the book is certainly an encouraging one for those of us who believe in the values of democracy. Running through it is the belief that an autocratic organization contains the seeds of its own disintegration through production of hostility and through lack of participation by members of the group. Many examples can be cited to support this position.

However, there is a disturbing complacency about the book. One of the authors, Dr. White, is an analyst of communism and has inserted political commentary that encourages the reader in his already natural predilection to identify autocracy as defined by these authors as characteristic of the Soviet Union.

In some ways the domestic policies of the Soviet Union fit this definition of autocracy, but in other ways they bear no resemblance to it. The aim of the leader in a Soviet youth group is to train a group that commands individual loyalty and operates its own strong social controls without the necessity of an adult leader. The establishment of clear long-range goals is a traditional domestic policy of the Soviet Union in all its 5-year plans. The basis of evaluation of the individual's activity is made crystal clear in Soviet groups. That ethic is the subordination of the individual to the interests of the collective—not the leader but the collective. To be sure, that ethic must be accepted without question. In that sense it is prescribed, but it is perfectly clear.

White and Lippitt say that conscientiousness is an asset for democratic group membership. This is true but it is also an asset for communist group membership, and much effort is expended by Soviet educators in building a "communist conscience" well buttressed by guilt feelings in case of transgressions and by methods of expiation.

On the other hand there have been frequent reports of a high degree of interpersonal hostility, and suspiciousness among Soviet citizens toward each other. This fits the picture of autocracy described by White and Lippitt.

The truth is that the group atmosphere the Soviet educators strive to produce is neither autocracy or democracy nor anything in between. It represents a new departure in education. It is doubtful if any of us would enjoy living in that atmosphere but we cannot be complacent in the belief that communist society is destroying its own cohesiveness or its task orientation by being autocratic in the traditional sense.

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[1] White, Ralph K.; Lippitt, Ronald O.: Autocracy and democracy; an experimental inquiry. Harper & Bros., New York, 1960. $6. 330 pp.

BOOK NOTES

HANDBOOK OF RESEARCH METHODS IN CHILD DEVELOPMENT. Edited by Paul Henry Mussen. John Wiley & Sons, New York. 1960. 1,061 pp. $15.25.

Twenty-nine experienced investigators in child development research have contributed to the 22 chapters in this book, reviewing research methods and the challenges confronting research workers in this field.

The book opens with a broad discussion of why and how children are studied, ranging from the philosophy of science to the procurement of subjects. The next chapters discuss general methods of child development research, including observation and laboratory experimentation. The book then moves on to specific methods for studying specific aspects of development—physical growth, the cognitive processes, personality development, and social behavior. Included, among others, are chapters on problem solving and thinking, psycholinguistic research methods, interviewing children, projective techniques, the measurement of children's attitudes and values, the appraisal of personality characteristics, interpersonal behavior, and the measurement of family life variables.

THE DEVELOPMENT OF THE INFANT AND YOUNG CHILD, normal and abnormal. R. S. Illingsworth. E. & S. Livingstone, Edinburgh. 1960. 318 pp. Available through the Williams & Wilkins Co., Baltimore, Md. $6.50.

This book on the mental development of the infant and preschool child, written primarily for physicians, discusses prenatal, perinatal, and environmental factors in mental development; the association of mental development with physical defects and diseases; variation in the general pattern of development in its different aspects, and in individual children; and the relative importance of the different aspects. The author is professor of child health at the University of Sheffield, England.

Reviewing a large number of studies of tests of infant development, the author suggests some reasons for the nonpredictiveness of some of them.

The book also describes normal development up to 6 years and factors that affect development, notes variations in general development and in individual aspects of it, discusses history taking, and offers detailed instructions for evaluating the developmental status of a child at birth and at various ages up to 5 years.

The author concludes that developmental tests in infancy can detect with some certainty mental retardation and neurological conditions, but that there is little evidence that mental superiority can be detected at that stage of life.

GUIDANCE OF THE YOUNG CHILD. Louise M. Langford. John Wiley & Sons, New York, 1960. 349 pp. $6.25.

This textbook for courses in child development, is written specifically for students in teachers colleges, junior colleges, and high schools where observation and participation in a nursery school laboratory is part of the instructional set-up, but the author has expressed the hope that it will be useful to any adult responsible for guiding preschool children. The book is directed at helping adults in their efforts: (1) to learn something about how children develop and to recognize signs of progress toward maturity; (2) to find out how children feel about themselves, about other people, and about their experiences; and (3) to develop a philosophy of child guidance that will permit children to develop their individual potentialities and to learn the controls they will need in the future.

The author, who is assistant professor in the department of family and child development, School of Home Economics, Kansas State University, traces the physical, social, emotional, and mental development of preschool children and stresses that the choice of guidance methods must be based on knowledge of the individual child. Specific suggestions for positive guidance are included.

EARLY IDENTIFICATION OF EMOTIONALLY HANDICAPPED CHILDREN IN SCHOOL. Eli M. Bower. American Lecture Series, Publication No. 404. Charles C Thomas, Springfield, Ill. 1960. 120 pp. $5.50.

Citing the resilience of childhood as the basis for the hope of reducing emotional disturbance when discovered early, this book describes a screening method for teachers' use in recognizing children who are becoming emotionally maladjusted. The author emphasizes the word "screening," pointing out that the method is not intended to diagnose emotional disturbance as a clinician would, but rather to assist teachers in identifying children who need help. The book reports on a research project carried out in California, designed to determine the extent to which certain information available to the teacher in day-to-day work can be used to identify such children.

Early in the study 200 children in the fourth, fifth, or sixth grade were found by clinical diagnosis to be emotionally handicapped. Later when some classes in those grades were selected to test the validity for screening purposes of the day-to-day information available to teachers, the teachers were not told that there was at least one emotionally handicapped child in each class. The teachers collected specified information concerning each child: his age; his absence record; his family's socio-economic status; his scores in reading and arithmetic tests and in a group intelligence test; and his own opinions of his adjustment as shown in a personality self-measurement inventory and in a sociometric device through which he characterizes, by implication, himself and his classmates. The teacher also rated the child's physical and adjustment status.

Comparison of the clinical diagnoses with the identification by screening demonstrated the feasibility of the screening method in the opinion of the author.

CEREBRAL PALSY AND RELATED DISORDERS: a developmental approach to dysfunction. Eric Denhoff and Isabel Pick Robinault. McGraw-Hill Book Co., New York. 1960. 421 pp. $12.

On the ground that cerebral palsy and related types of impaired functioning result from influences operating while the central nervous system is developing—prenatally or later—the authors of this book state that the condition is "ever-changing" and that treatment should continually be adapted to the child's developmental status and his changing potentialities.

The book offers detailed suggestions concerning diagnosis and habilitation of cerebral-palsied children and those with associated handicaps reflecting a damaged brain, such as mental deficiency; visual, aural, or perceptual problems; and speech, behavioral, and emotional disturbances. The authors recommend what they call a developmental approach to treatment, the keynote to which is periodic reevaluation by each member of a team of specialists in medical and other disciplines, with a pooling of all findings. Such an approach, they explain, "pivots around abilities rather than disabilities."

THE ROOTS OF CRIME. Selected Papers on Psychoanalysis, Vol. 2. Edward Glover. International Universities Press, New York. 1960. 422 pp. $7.50.

The object of this book, says the author, is "to support and conceivably augment the authority of the clinical psychologist in the study, treatment, and ultimately prevention of pathological delinquency." His stated approach to the problem is psychoanalytic as opposed to penal.

As in the field of organic medicine, prevention is better than cure and in the long run cheaper, the author maintains, and he states that we have a clear pointer toward policies of prevention in improving the upbringing of children from birth onward. He urges that the child be brought up in an atmosphere of security and affection, that his sexual education be sane and candid, and that parents provide "an example of law-abidingness."

The book outlines the history of the investigation of adult and juvenile delinquency in Great Britain, discusses the diagnosis and treatment of pathological delinquency, reports on criminal psychopathy and sex offenses, stresses the need for liaison between disciplines in carrying out clinical research on delinquency, and includes a chapter on sociolegal aspects of delinquency.

CHILDREN'S BEHAVIOR. Sophie Ritholz. Bookman Associates, New York, 1959. 239 pp. $5.

When asked to measure the relative gravity of a child's behavior disorder, teacher and parent tend to use as yardsticks their own plans and performance goals—and both tend to rate differently from the mental hygienist. So reports the author, a psychologist and psychoanalyst, in this account of studies of comparative attitudes toward children's behavior, carried out in 1944–45. The author cites teachers' serious views of disorderliness, restlessness, and inattention, considered less serious by parents and unimportant by mental hygienists. Conversely, the withdrawing, recessive personality traits, which top the mental hygienists' list, are regarded as unimportant by teachers and only slightly more important by parents.

The studies used as core material a list of 50 behavior characteristics for such studies by another investigator, E. K. Wickman, in 1924–28 among teachers and mental hygienists. The author surveyed responses from 220 teachers in public elementary schools, 142 parents, and 406 pupils in 5A, 7A, and 8B, in New York City.

Among the author's findings was that teachers' rating patterns in 1944–45 were closer to those of mental hygienists than they were in the twenties but were still further removed than those of parents.

HERE AND THERE

Health Message

Three recommendations concerned with children and youth were included in President John F. Kennedy's message on health and hospital care sent to the Congress on February 9. They included:

- The establishment in the National Institutes of Health of a National Institute of Child Health and Human Development to include a center for research in child health and "other broad-ranging research activities" not now covered by the other institutes.
- An increase in the appropriations for the maternal and child health, crippled children, and child welfare programs of the Children's Bureau.
- Designation of the Secretary of Health, Education, and Welfare as chairman of the President's Council on Youth Fitness, charged with mobilizing resources to encourage interest in physical fitness and reporting on the adequacy and needs of school health programs and the possible role of the Federal Government in stimulating such programs.

The President also called for a three-pronged program to increase the number of medical and dental school graduates. This would include grants to universities for designing facilities for medical and dental schools, matching grants for construction of such facilities, and grants to medical and dental schools for scholarships and other costs of training.

Prior to the message the President had already taken steps to establish a Child Health Center, through an order to the Surgeon General of the Public Health Service to set up a research center to deal with the special problems of children. In his announcement of this, on February 8, the President especially emphasized the need for research into the causes of congenital malformations and mental retardation.

According to Secretary of Health, Education, and Welfare, Abraham Ribicoff, the center will be set up within the Division of General Medical Sciences at the National Institutes of Health. The Secretary has announced that the center will bring together the research efforts of the Public Health Service which are directly or indirectly concerned with children, and that its work will be closely coordinated with the programs of the Children's Bureau.

Task Force Report

Currently under study at the Department of Health, Education, and Welfare is the report made by the Task Force on Health and Social Security to President Kennedy just before his inauguration. Among the recommendations are a number concerned with children. These include:

- *The creation of a National Institute of Child Health* within the National Institutes of Health to be concerned with research into the physical, intellectual and emotional growth of the child. In addition to research workers in the fields of genetics, obstetrics, psychology and pediatrics, the staff of the institute would include "basic scientists" to study the normal process of human maturation from conception through adolescence. The institute would conduct its own research program and make grants to stimulate programs elsewhere.
- *Assistance to Children of an Unemployed Parent.* This would be a temporary provision added to Title IV of the Social Security Act pending the adoption of a comprehensive family and child welfare services plan.
- *The development of a Family and Child Welfare Services Plan.* This would bring together in one program Federal aid to the States under the Social Security Act, for assistance and social services to needy families and children and community social services in such areas as juvenile delinquency prevention, services to the aging, and other related programs designed to strengthen community life.
- *Transfer of the Children's Bureau* from the Social Security Administration to the Office of the Secretary to serve as "a staff agency concerned with all the problems of child life and the promotion of new programs to meet them rather than with program operations."
- *Creation of an Institute of Family and Child Welfare Research* associated with the Social Security Administration to combine the present research and demonstration functions enacted in 1956 and now vested in the Social Security Administration, including those of the Children's Bureau in the child welfare field.
- *Transfer of the administration of the Maternal and Child Health and Crippled Children grant programs* to the Public Health Service.
- *Transfer of the administration of the Child Welfare Services* program to the Social Security Commissioner pending the development of the Family and Child Welfare Services plan.

Members of the task force were:

Wilbur J. Cohen, Chairman, professor of Public Welfare Administration, University of Michigan; *Dean A. Clark, M.D.*, general director, Massachusetts General Hospital, Boston; *Robert E. Cooke, M.D.*, professor of pediatrics, Johns Hopkins University, School of Medicine; *James Dixon, M.D.*, president, Antioch College; *Joshua Lederberg*, professor of genetics, School of Medicine, Stanford University; *Herman M. Somers*, chairman, Department of Political Science, Haverford College; *Elizabeth Wickenden*, acting director, Project of Public Services for Families and Children, New York School of Social Work, Columbia University.

ADC and "Suitable Homes"

After July 1, 1961, a State in which the plan under the aid to dependent children program denies assistance to a needy child on the basis of the unsuitability of his home but leaves the child in that home exposed to its unsuitable conditions will no longer be eligible for Federal ADC grants, according to a new ruling of the Department of Health, Education, and Welfare, announced on January 17 by the Secretary, Arthur E. Flemming.

The ruling grew out of the Social Security Administration's investigation into the effects of suitable homes provisions adopted by the 1960 Louisiana Legislature which had resulted in 23,000 children being dropped from the State's ADC rolls last July. (See CHILDREN, November–December 1960, page 241, and January February 1961, page 36.) It requires States with such provisions to continue assistance to otherwise eligible children in homes regarded as unsuitable "during the time efforts are being made either to improve the home conditions or to make arrangements for the child elsewhere."

The new requirement, which will affect current practice in a few other States besides Louisiana, was announced concurrently with the Social Security Commissioner's decision in the Louisiana case. In that decision the Commissioner found that while the State's action following the suitable homes legislation was "clearly in violation of the requirements of the Social Security Act," subsequent revision of its ADC plan and assurance given to the Department by the Louisiana Department of Welfare concerning its "prospective administration" brought the State in conformity with present requirements for Federal aid.

The Commissioner pointed out that he was "constrained" to arrive at this decision because under the law Federal grants must be made on the basis of a situation as it exists now; but he added that he had done so with "some reluctance" in view of the "immeasurable and unnecessary privation and suffering" brought upon thousands of children through the effect of the Louisiana law and "a perhaps overzealous interpretation and implementation of it."

The assurances from Louisiana referred to by the Commissioner did not abrogate the State's suitable homes provision but they did promise that homes would not be deemed unsuitable without substantiating information, that in active cases payments would not be missed while the home is under investigation, and that closed or suspended cases would be given written notice of their right to a hearing before the State agency.

In his decision the Commissioner pointed out that in the absence of any precedents or policy prohibiting States to use "suitable homes" as an eligibility condition, a State's imposition of such an eligibility requirement does not alone constitute a circumstance calling for Federal disapproval of a State's ADC plan, "even though the result might be, in some cases to deny subsistence needs to children while they still remain in an environment found to be unsuitable." Pointing out that the Louisiana case had underlined the seriousness of the social and economic problems which arise from a "suitable home" requirement, "particularly in situations where no supportive programs are available to deal with the consequences of a denial of benefits," he added: "Therefore, for the future it has been decided to deal with this situation by a modification of our present requirements."

The bases for the new ruling, spelled out in a memorandum from Secretary Flemming to the Commissioner, were released at the time of the announcement. In it the Secretary outlined the points on which he had determined that "when a needy child who otherwise fits within the aid to dependent children program of the State is denied the funds that are admittedly needed to provide the basic essentials of life itself, because of the behavior of his parent or other relative, the State plan imposes a condition of eligibility that bears no just relationship to the aid to dependent children program."

These points in brief were that:

- Withholding funds needed for subsistence in an effort to make an adult's conduct more acceptable is unconnected with the ADC program's goal of providing financial assistance or social services to needy children—the State has other means of action if an adult's conduct violates public policy.
- Depriving a child of the means of subsistence does not improve the environment of an unsuitable home.
- A State that "withholds assistance from children for the purported reason that they are not living in a 'suitable home' and yet does not think that the environment is detrimental enough to warrant removal of the child from his own home in his best interest, is not using the Federal grant for the purpose of encouraging the care of dependent children in their own home, strengthening family life, or helping parents to attain the maximum self-support and personal independence consistent with the maintenance of continuing parental care and protection."

In reaching the conclusion that he had no choice but to order a change in current practice, the Secretary referred to statements adopted by numerous welfare and church organizations, quoting specifically from those of the American Public Welfare Association, the National Social Welfare Assembly, and the Minnesota Welfare Conference.

In line with this determination the Director of the Bureau of Public Assistance has sent a letter to the States informing them of the new requirement.

Recommendations on Day Care

While the final reports of the work groups of the National Conference on Day Care for Children, held in Washington, in November (see CHILDREN, January–February 1961, page 33) have not yet been received, preliminary reports prepared at the Conference stress throughout, the view of day care as a part of total community services to be used on the basis of individual need. Such needs were seen as arising from (1) economic problems, (2) environmental problems, (3) family relationships, and (4) health problems.

Included among the specific recommendations were, in brief, the following:

- That every day care program have a clear relationship to community needs and resources.
- That programs for school-age children have a carefully worked out relationship with schools and teachers.
- That provision for day care for families with special needs be one of a range of services to choose from, including information and counseling, financial assistance, homemaker service, both foster family and group day care, and special treatment services.
- That children in day care be protected by an effective licensing program, with responsibility for standards, coordination, and enforcement lodged in the State.
- That licensing standards cover personnel and program as well as standards of sanitation, space, and safety.
- That standards for day care be the same for public or private operations, and that training goals for staff be equal to those of other educational endeavors and include knowledge of child growth and development of children of all ages up to 12.
- That Federal support be available for training day care staff, and that agencies sponsoring day care programs provide educational leave and inservice training opportunities to the members of the staff.
- That national agencies as well as local communities develop recruitment programs for day care staff.
- That fact-finding efforts be undertaken by Federal, State, and local agen-

cies to secure: comprehensive operating statistics on the day care services being provided by public, voluntary, and proprietary agencies; estimates of the current and anticipated need for services; information, through research studies, on the individual and social problems arising when day care is not available, on the effectiveness of specific types of programs, and on ways of determining priorities for day care in relation to other needed services.

- That public funds from all levels of government be sought to supplement present efforts to meet the day care needs.
- That Federal funds for day care be administered in a flexible manner through contracts with local agencies, committees, or day care centers.
- That future national studies of day care needs include such financial data as per-capita costs, salary classifications, and other budgetary aspects which will be helpful to communities planning programs.

Child Guidance

Many behavior problems have been eliminated or reduced in the children treated at the child guidance centers operated by the Washington State Department of Institutions, in the opinion of their parents, according to results of a study recently made by the department.

The department requested the parents' opinions through a questionnaire concerning each of 359 children discharged from treatment during a specific period. Six months after the child made his last treatment visit, parents were sent a copy of the questionnaire, asking about changes in the child's behavior since the beginning of treatment.

The parents of two-thirds of the children replied in time for the study analysis, and the answers showed that of the main behavior problems occurring in the children at the time they began treatment 20 percent no longer existed, 52 percent were reduced in severity, 21 percent showed no change, and 3 percent were considered worse. For problems considered minor the percentages were similar. Among the problems were disobedience to parents or other adults in authority; school failure; excessive fighting; temper tantrums; repeated lying; stealing; unacceptable sexual behavior; and running away.

Other questions concerned the child's present adjustment to the family, to school, and to the neighborhood; and any misbehavior, since treatment, that involved the child with school authorities, law-enforcement agencies, the juvenile court, or correctional institutions. From the point of view of delinquency prevention, the department found the responses encouraging: for example, of 151 replies only 6 percent indicated that the child had become involved with a correctional institution.

WHITE HOUSE CONFERENCE

State Activities—A Year Later

The first anniversary of the 1960 White House Conference on Children and Youth finds 42 of the 55 United States jurisdictions planning or carrying out statewide activities to follow up Conference recommendations. At the time of the Conference, 53 of these jurisdictions (including all the States) had gubernatorially appointed committees on children and youth which participated in the Conference, reporting on the conditions and needs of children in their areas. Many of these committees had been active since 1950, or even since the 1940 White House Conference. The score of such committees now is:

1960 Conference committees still active	28
Newly organized committees	6
Committees proposed in pending legislation	4
Committees being planned	4

The 34 committees now active have the following characteristics:

Structure

Appointed by the Governor	15
Appointed by the board of control	1
Established by legislative action	12
Established by State welfare associations	2
Unofficial, self-perpetuating	5

Financing

Financed by legislative appropriation	11
Funds received from the governor	4
Financed by one State department alone	7
Financed by more than one State department	13

Staff

Paid staff	28
Without paid staff	6

Organization

With county committees	21
With regional committees	5
With both regional and county committees	7
State level operation only	8

In addition to the State committees for children and youth, youth councils composed of young people exist in 9 States, and are in the planning stage in 6 more. Three of the 9 were sponsored by the State's youth committee, 2 were appointed by the governor, and 1 was organized by the young people themselves.

In 8 States the youth committees have developed cooperating councils of State organizations, made up of representatives of statewide organizations, including State affiliates of many national organizations; 5 additional councils are in the planning stage.

A question, "Do you think the services of the child guidance center were helpful to you?" brought 172 "yes" answers and 19 "no."

The report of the study, entitled "Child Guidance Evaluation Study," is available from the State Department of Institutions, Olympia, Wash.

Homemaker Services

On Monday, January 16, 1961, the sponsors of the National Conference on Homemaker Services (See CHILDREN, May–June 1959, page 108) voted for the creation of a new experimental, independent national organization, to be brought into being by the National Health Council and the National Social Welfare Assembly. The action was taken at a meeting in New York where the following motion was adopted: "The two coordinating agencies in the fields of health and social welfare might jointly seek foundations' support to provide the funds needed for a 5-year demonstration in the promotion of homemaker services of high quality in public and private non-profit organizations under various auspices, such promotion to include standard-setting, consultation, and research."

The purposes for which the organization was proposed were: to provide for exchange of experience among homemaker service programs; to provide a central point of information about homemaker services; to assemble material and study various methods of recruitment of homemakers; to develop desirable training programs for homemakers and the standards for such training; to explore legal and professional questions relating to homemaker service; to provide a centrally directed program of public information; to assist national health and welfare organizations in interpreting the value of homemaker services; to provide consultation in community organization specific to either health or welfare organizations, to existing homemaker services and proposed new services.

The new organization would have representation from both health and welfare interests on the board of directors and on the staff.

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Chicago's Child and Family Services is undertaking a pilot project to extend homemaker services to suburban areas and to expand these services in the city. This expansion, achieved largely by setting up two new district offices in the suburbs, is in line with recent recommendations of the Welfare Council of Metropolitan Chicago. The agency's staff of 25 homemakers will be augmented by 10 for work in the Chicago area; and by a total of 15 in the suburban offices. These suburban operations are scheduled for evaluation after 2 or 3 years in terms of feasibility and the possibility of financing from suburban sources.

An intensive study by the Council showed a total of 122 homemakers for the Chicago area, with little service for suburban residents. Most homemakers in the area are employed by the Cook County Department of Public Aid or by two sectarian agencies.

In recommending the Child and Family Services as the base for the expanded service, the Council pointed out the lower cost of expanding an existing service over the creation of a new one.

The Council also recommended extension of the public agency's homemaker programs.

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The Federation of Protestant Welfare Agencies in New York City has launched a new homemaker service agency called the Association for Homemaker Service. During the first year, the new service will have 10 to 12 homemakers working under a casework supervisor.

Adolescents

A study of the interests of boys entering adolescence, made for the National Council, Boy Scouts of America, was recently completed by the Survey Research Center, Institute for Social Research, University of Michigan. The nearly 2,000 boys who were interviewed represented a statistical sample of the Nation's boys aged 11–13 in school grades 4–8 and boys of other ages in grades 5–8. Each boy was interviewed for an hour by a trained field representative of the center.

Among the findings are:

- Sixty-five percent of the boys worried most about achievement.
- Movies and TV led all the out-of-school activities; indoor games came second; team sports third. Among outdoor activities most votes went to camping—1 in 4.
- Forty-one percent of the boys had no ties with organized groups other than athletic teams. Thirty percent belonged to a club but not a team. Twenty-seven percent belonged to neither an athletic team nor a club.
- Fifty-four percent of the boys had paying jobs.
- In response to a question asking what the boys would want a new club to do if one were started, 57 percent wanted emphasis on "sports and games"; 11 percent, on social activities.

The report of the study, "A Study of Boys Becoming Adolescents," is available from the National Council, Boy Scouts of America, $2.

Mental Retardation

The Child Study Center of the University of Washington in Seattle recently conducted a statewide study aimed at promoting early screening for phenylketonuria among children born into families in which there is already a child afflicted with the disease. According to investigators, the other children in these families have a one-in-four chance of also having this hereditary defect of metabolism. The disease causes mental retardation unless treated through a special diet in early life. (See CHILDREN, September–October 1960, page 198.)

Forty-one families known to have phenylketonuric children were visited by two medical students to find out how much parents knew about the condition and where they obtained medical care, and subsequently, the extent of their physicians' knowledge of the disease. In 29 of the homes visited, the parents knew nothing about the disorder; of the 13 who knew their child had phenylketonuria, 2 families did not know that subsequent children might be afflicted. Twenty-two of the mothers were still in child-bearing age.

At the project's end, the list of these families was turned over to the Washington State Department of Health as a core of a central registry to be kept up to date for close followup of tests on their newborn for phenylketonuria.

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The recent discovery of a chromosome abnormality—in the form of an extra chromosome—in mongoloid children has prompted the Dight Institute for Human Genetics of the University of Minnesota to urge young parents who have a mongoloid child to seek genetic counseling and to have a check of their chromosomes. Presence of the extra chromosome in the translocated form (see Penrose et al. in Aug. 20, 1960, *The Lancet*) would mean that the chances of the parents' next child being mongoloid would be one in four. The increased possibility of older mother's giving birth to a mongoloid child as the result of a different kind of dysfunction of the chromosomes affecting the child's genetics has been known for some time.

The Dight Institute has one of the few laboratories in the United States that make human chromosome preparations. In order for the test to be made the parents must appear at one of these laboratories with the mongoloid child.

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The research program of the National Association for Retarded Children, hitherto concentrated on studies looking for the causes of mental retardation, is expanding to include behavioral science studies dealing with the diagnosis, management, and training of retarded children, according to a recent announcement by the association. The association expects the new program to lead eventually to better diagnosis and training of the retarded, to programs designed to help them attain their maximum development, and to improved methods of teaching them.

Against Polio

Meeting in Atlanta late in January 1961, the Surgeon General's Committee on Poliomyelitis Control recommended that State and local health departments intensify their immunization programs with Salk vaccine to prevent epidemics in the 1961 season, recognizing that the oral vaccine will not be available then. The committee also recommended that the Public Health Service continue to encourage early output and ready availability of oral poliovaccine. Other recommendations made by the committee members, representing 28 participating agencies, public and private, were:

- Adoption of the "Babies and Breadwinners" campaign—designed to reach lower socioeconomic groups through neighborhood leaders by local medical societies, health agencies, and community organizations.
- Emphasis on getting everyone protected with at least 3 shots of Salk vaccine before summer 1961, if necessary spacing shots 2 weeks to a month apart.
- Periodic surveys of the community's immunization picture, using for example, the Indiana system, in which school boards report on the immunization status of each newly registered child.
- Behavioral studies to pinpoint the reasons for nonacceptance of poliomyelitis immunization; and further research on inactivated and living virus vaccines.
- Priorities for using the first supplies of the oral vaccine, if they are limited, in the following order: (1) epidemic control, investigation, and community studies; (2) immunization of infants and preschool children; and (3) for population groups the least well immunized.
- Maintenance by the Public Health Service of oral vaccine reserves for emergency use.

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Although infants and children under 5 years of age have accounted for most cases of paralytic poliomyelitis, 20 percent of this age group have had no vaccination against the disease, according to estimates based on a survey conducted by the Bureau of the Census for the Public Health Service in September 1960. This figure represents only a slight improvement over the estimate of 23 percent for 1959.

The proportion of preschool children and infants with three or more doses of the Salk killed virus vaccine has risen to about 62 percent in 1960 from 54 percent in 1959. Of the 8 million inadequately protected in this age group, 3.8 million have had one or two doses of vaccine and 4.1 million none. As in previous years, the age groups best protected are those between 5 to 10 years, with 84 percent having had three or more doses; and those between 10 to 20 years, with 80 percent fully vaccinated.

In all, the estimates show that 60 percent of the Nation's population under 60 years of age have had at least one dose of the Salk vaccine, compared with 56 percent the previous year. Most of the 1960 vaccinations were booster shots. About 25 percent of the population have now had four or more doses.

Social Research

In recognition of "the insistent need for supporting more fundamental studies in the social sciences" the National Science Foundation has announced the creation of a Division of Social Sciences to take the place of its former Office of Social Sciences. The new division will organize the Foundation's support of basic research in the social sciences under four programs: (1) anthropological sciences—including ethnology, archaeology, linguistics, and physical anthropology; (2) economic sciences—including econometrics, economic and social geography, the economics of research and innovation and general mathematical economics; (3) sociological sciences—including demography, social psychology, psycholinguistics, and the sociology of science; and (4) a program supporting basic research in the history and philosophy of science.

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A project to study how social work practice can be applied to the control of social problems in neighborhoods was recently launched by the National Association of Social Workers with a grant of $18,000 from the Ford Foundation. The project is based on the premise that a number of recent developments in social work, when taken in relation to one another, offer a promising approach for more effective handling of community social problems. Among the developments are research and experimentation in work with "multiproblem families," as conducted by the Community Research Associates, the coordination of community services to help such families as in a project carried out by the Greater St. Paul Community Chest and Council, and "reaching out" to families through the use of group workers and the community organization techniques that are directed toward stimulating neighborhood action.

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A compendium of all the recommendations concerning research developed by the forums of the 1960 White House Conference on Children and Youth has been published in a single volume entitled "Prospectus on Research."

The opening chapter presents the major themes of the research recommendations, including among others: the family; self-scrutiny and understanding; improved communication; program research and evaluation. Further chapters, in addition to classifying and summarizing specific recommendations, discuss the possibilities for their implementation and support and present some critical questions affecting the development of research programs.

The publication may be obtained from the U.S. Government Printing Office, Washington 25, D.C. Price 25 cents.

IN THE JOURNALS

Eliminating the Waiting List

The January 1961 issue of *Mental Hygiene* carries an article describing the way a new outpatient psychiatric center, the Bradley Center in Columbus, Ga., met the challenge of waiting lists for child guidance and marital counseling. ("Meeting Problems of Intake.") The author, Ruth Charlton Oakey, the center's chief psychiatric social worker, outlines the techniques used: (1) sufficient reallocation of the staff's professional responsibilities; and (2) the innovation of information forms which the patients completed before the intake interview.

Through redefining the functions of the psychiatric social worker, the psychiatrist, and the psychologist, the routine practice of involving all three disciplines in each new case was replaced by their functioning independently yet collaboratively. Under the new system, the psychiatrist initially sees all patients for diagnosis and disposition. Where there is primarily conflict of family relationships, the case is directed to the psychiatric social worker. When referral to the clinic is based mainly on such problems as learning difficulties or bizarre behavior, the case is referred to the clinical psychologist.

Miss Oakey outlines the various types of pre-intake questionnaires and check lists which, in her opinion, have enhanced the clinical study of patients. The Center's experience with both of these procedures, she writes, have shown that they not only reduce considerably the total time of the intake process but eliminate the waiting lists as well.

The Meaning of Separation

The reactions of five emotionally disturbed boys to the prospect of separation from a residential treatment center, when the center was about to close down, are reported by Victor R. Stoeffler, psychiatric social worker at the National Institute of Mental Health, in *Social Casework* of December 1960. ("The Separation Phenomenon in Residential Treatment.") The boys were among the eight highly aggressive children who received intensive treatment and study for 5 years in a special project of the National Institute of Mental Health. ("Child Study in a New Setting," by Fritz Redl, CHILDREN, January–February 1954.)

Ranging in age from 12 to 14 years, the boys all had histories in which the theme of separation was prominent. Among their outstanding reactions to the news that they were to be placed elsewhere, as interpreted by the author, were severe depression and fear of expressing the loss which the closing of the residence symbolized. The expression of loss took the form of a display of fondness for the furniture or collected objects. Bedtime—representing an impending separation—became a difficult period. The boys also relived disturbing past experiences, and in recalling the past, showed nostalgia for previous stages of their treatment, as if retrogression would ward off the need to separate. As the security of the milieu crumbled, feelings of rejection were expressed through fire setting, overt sex play, stealing, and hostility toward the staff.

The author considers it significant that the boys' final acceptance of the separation was accompanied by feelings of anticipation about the new placement, initiated and encouraged by the staff, and by development of the ability to face the facts about their own homes.

Reorienting Behavioral Studies

In the *Social Service Review* of December 1960, Charlotte Towle sketches briefly the aims and content of a course on growth and personality, taught at the School of Social Service Administration, University of Chicago. ("A Social Work Approach to Courses in Growth and Behavior.") Developed over the past 3 years at the Chicago school, where the author is a faculty member, the course is designed to strengthen areas traditionally presented inadequately for the kind of understanding a social worker needs. For example, she points out that thinking of personality characteristics in terms of absolutes—the individual is sick or well—must be oriented to the realization that any normal person might react pathologically to prolonged stress.

The course as described teaches students to assume that an individual with pathological behavior has potential for recovery, until he proves the contrary. In this connection, the course delineates criteria for normal ego functioning under stress as compared with ego dysfunctioning characteristic of pathology.

Miss Towle says that in the course adaptive and defensive behavior is conceived as a resource of the ego rather than evidence of its failure. She points out that this understanding is basic to skills which social workers use to help people cope with stress.

Instead of presenting man "as id, ego, and superego," the course weaves together four areas; ego-superego development and integration of learning; behavior dynamics in goal striving; maturation and acculturation expectancies; developmental norms; the individual in society—using vignettes of individuals under stress, as examples.

Position of the Newborn

Diaper rash, self-inflicted scratch marks, and crying occurred more frequently among infants placed in the supine rather than in the prone position, in a study carried out in the nursery of a Philadelphia hospital and reported in the December 1960 issue of the *Journal of Pediatrics*. ("Diaper Rash, Self-Inflicted Excoriations, and Crying in Fullterm Newborn Infants Kept in the Prone or Supine Position," by H. G. Keitel, R. Cohn, and D. Harnish.)

The authors recommend that this be considered in the care of newborn, especially in hospitals where nursery personnel is in too short supply to make it possible to change the babies frequently. The study included 140 babies placed in the supine position and 141 babies in the prone position.

Combating Staff Shortages

Because person-to-person relationships are vital to child welfare services, the shortage of trained personnel in this field has an acute effect on operations, warns Howard J. Parad writing in *Child Welfare* of January 1961. ("Social Work Training for Child Welfare—Some Key Issues.") Only 20 percent of the staff in child welfare agencies and 4 percent in public assistance agencies have professional training, and of the professional group in child welfare about one-quarter leaves the field annually. Dr. Parad, who is director of the Smith College School for Social Work, compares an estimated national need of 10 to 15 thousand recruits annually for social work with the 2,000 graduating each year.

To fill the gap, the author advocates the use of junior professional workers, or case aides, with safeguards against downgrading the profession including standards for acceptance that would qualify the person for admission to a graduate school, a limited time for employment, and strengthened inservice training programs. He also recommends the extension and elaboration of social work career programs which give on-the-job summer experience in social agencies to college students.

Training curriculum, in Dr. Parad's opinion, should reflect the fact that success in social work hinges on a fusion of thinking, acting, and feeling and therefore should achieve a balance between rarified intellectualism and learning by intuitive trial and error.

For the efficient deployment of scarce personnel, Dr. Parad proposes new types of organizational structures integrating a variety of family focused services.

Employed Mothers

One can say almost anything about children of employed mothers and support the statement by some research findings, says Lois Meek Stolz in the December 1960 issue of the quarterly, *Child Development.* ("Effects of Maternal Employment on Children: Evidence from Research.") In a review and analysis of research on working mothers and their children, she gives as examples documentation for conflicting statements on the relation of maternal employment to juvenile delinquency, adjustment of adolescents, school achievement, and preschool development.

However, she reports that studies made since 1946 with adequate control of relevant variables have shown no significant relation between maternal employment and the behavior, adjustment, or school achievement of their children; and adds that maternal employment in itself may be a less important factor in determining the behavior of children than many assume.

The author, a psychologist on the staff of Stanford University, conjectures that divergent findings may stem from inadequate control in some studies of pertinent variables, such as socioeconomic status and intactness of family as well as time of data collection.

Suggestions by the author to future investigators concern more precise definitions of maternal employment and nonemployment, fuller consideration of the effects of time and place requirements of the mother's work on family life, and attention to differences in defining behavior and in methods of collecting data on it. The review concludes with the prediction that unless this research takes into account variations in the nature of maternal employment and the complex interpersonal family relations, results will continue to be inconclusive.

READERS' EXCHANGE

TROUT: *Professional services for all*

Bessie Trout's article on the use of staff does the child welfare field a service by deducing some general principles from a variety of experiments in child welfare agencies that are trying to differentiate tasks appropriate to professional and non-professional staff members. ["The Use of Staff in Child Welfare Services," CHILDREN, January–February 1961.]

The critical shortage of social work personnel will not be solved by recruitment alone. Ways must be found to conserve professional services by using social workers in tasks that call for all their professional knowledge and skill. Commonly, professional social workers are either wholly engaged in supervising workers who, without professional preparation, carry the entire direct relationship with the child and family, or they are giving direct services that include many tasks for which professional skill is not really required.

Although no ready answer is available, it seems clear that a program of the needed quality must aim at a direct professional relationship with the client in the diagnosis and treatment of all the families and children served. No satisfactory way has been found to separate cases into a "difficult" group that requires the service of a professional worker and a "less complex" group that can do with less.

It is to be hoped that future analysis of the kind Miss Trout describes will enable us to define the professional component required for service in every case and the aspects of service that can be carried in the same cases by persons with lesser degrees of knowledge and skill, but with equal commitment to helping children and families towards better functioning.

Particularly valuable, I believe, is Miss Trout's perception that such a program can enable both kinds of staff members to give themselves more creatively and with intenser interest to their own share of the service to the client. The consequences Miss Trout anticipates are of the highest importance—greater "accountability," each part of the service having "a meaning to the whole," and "a boost in staff morale."

Mary R. Baker
Consultant on Careers in Social Work, Council on Social Work Education.

CLASS AND BINDER: *More goals for licensing*

The article, "Foster Care Licensing in Public Welfare" [CHILDREN, January–February 1961], could well be used to make clear in a limited sense the function of the licensing worker, because it represents something of a job analysis or job description. First, however, "foster care" should be defined.

I agree with the authors' description of the license seeker as a person with "a vested interest," but they neglect to point out the positive value of having the parents pay for child care according to their ability, as an important means of strengthening the parent-child relationship. Parents may in this way maintain a feeling of having priority responsibility for their child.

With an expanded objective for the licensing program which is more nearly what actually exists in practice in most States, the tools of the licensing worker increase. The licensing worker must have knowledge of community organization, casework, group work, and administration. The authors imply the need of this knowledge when they indicate that related agencies must play a role in licensing and that the function of the department of public welfare is to coordinate these cooperative activities and to educate. This puts the licensing worker in a unique position to help those in other departments appreciate the value of the casework and educational methods of accomplishing their objectives. The group work method can be the vehicle for ideas and attitudes that create a feeling tone tending to modify the approach of each worker. I would expand the listing of personnel qualifications for licensing to include skills in group work and in interviewing and an understanding of educational methods.

In summary, the basic premise of the authors hinges upon their definition of the purpose of licensing. They contrast the altruistic motive of the applicant in past years with the motive of financial gain frequently found today. They advise "internalized" enforcement to release the energy of the licensing staff for more constructive activity.

It is my contention that the purpose of licensing is broader and the role of the licensing worker is greater, in that the licensing process involves casework, community organization, group work, and administration. Also, it provides a fertile generic base for social work education.

Lucy Brent Tolbert
Regional Child Welfare Supervisor, State Department of Public Welfare, Texas

PEAY: *Research Needed*

Roberta Peay's article, "Emotional Problems of Children Facing Heart Surgery," is a timely one, as little has been written about this subject. [CHILDREN, November-December 1960.]

We too find that the children mirror their parents' attitudes toward their condition and incorporate their concerns and anxieties. It is our impression that the younger the child at the time of diagnosis and the longer the period during which the child and parents can reinforce their concerns and attitudes, the harder it will be to reduce the degree of "cardiac neurosis." We find it most helpful to recognize with parents the weightiness of their decision to proceed with surgery and their helplessness during the immediate postoperative period. Most parents withstand the crisis well. Immediately following this, many experience depression and new anxiety upon resuming the parenting role of giving physical care.

Our followup experience differs from that reported by Miss Peay in that we find continued "cardiac neurosis" in many of the children in the early adolescent age group.

Most striking is the absence of research in this area of emotional problems of children with congenital heart disease.

Out of the mass of data available to us can we determine which factors or constellation of factors bearing on the child with heart disease are most significant for his psychosocial development? Can we then predict with greater accuracy how he will cope with the stress of hospitalization and surgery and consequently better time our intervention and improve our treatment methods? The implications of research for the prevention of unnecessary stress are self-evident.

Marilynn Willner
Principal Medical Social Worker, University of California Medical Center, Los Angeles.

MOOR: *Resources for the Blind*

In her paper, "Blind Children with Developmental Problems," Pauline Moor defines a problem area both cogent and pressing to those involved in work with blind children. [CHILDREN, January–February 1961.] Drawing on her wide experience, she presents a clear discussion of the causative factors of developmental problems in some blind children in such traditional terms as the experiential, emotional, and neurological.

Miss Moor, however, fails to stress a fourth and very basic element in her discussion—the dynamic dimension of the sociocultural. The implications of human relationships include not only a view of the child as a person but also of the features relating to his parents' role in the community. The need for readjustment of both parent and society must be considered.

No person operates in a vacuum. The interrelations between a person and his primary group, and those in turn between the primary group and the community at large combine to interject problems of adjustment for all concerned. We are beginning to realize that we know relatively little about such human resources as an intimate supportive relationship and its meaning and function in our culture.

Is it altogether surprising that having isolated blind children from their families and communities by placing them into separate, however adequate, environments we have not learned to live with them, love them, and help them adequately? What are we giving in terms of emotional support and social recognition to their parents and families?

To make another point, along with the "appropriate services" suggested by Miss Moor one might add the need for long-term treatment facilities for those children who are not ready to take part in any kind of educational program, residential or otherwise. Ideally, such a treatment center is best located in or near the child's home community. This combines opportunities for growth on the part of the child with help designed to increase understanding of him in his family.

The child needs to build healthy emotional relationships in the safety of a friendly and consistent environment. In such a situation, his family may for the first time experience a sense of hope and satisfaction by seeing responsiveness develop. The experience may help family members to realize the rewards of placing value, without any penalty, on the child's personality and its potentials.

Mariella B. Spencer
Medical social worker, St. Paul, Minn.

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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RESEARCH RELATING TO CHILDREN. Bulletins 11 and 12. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. August 1959–January 1960. 148 pp. (11); February–July 1960. 128 pp. (12) $1 each.

As in previous issues, these bulletins include reports of research in progress or recently completed in a number of fields concerning children, such as growth and development; personality and adjustment; educational process; exceptional children; the family; social, economic, and cultural influences; and health and social services. Only projects that were first reported to the Bureau during the designated period are included.

ASEPTIC NURSING TECHNIQUES: a survey of maternity departments in thirteen medical centers. Margaret W. Thomas. Department of Health, Education, and Welfare, Public Health Service. PHS Publication No. 788. 1960. 145 pp. $1.

Written by a consultant nurse to the Children's Bureau, this report presents the results of a survey of nursing practices in relation to the prevention and control of infection in the newborn nursery units of 13 large medical centers and of a study of standards and procedures recommended by selected authoritative groups. It also includes an interpretation of the recommendations in relation to principles of nursing care, as well as suggestions for practices concerning which no recommendations were available.

THE MONGOLOID BABY. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 50. 1960. 20 pp. 10 cents.

One of a series for parents of handicapped children, this booklet tells of some ways in which mongoloid babies differ from normal ones, discusses questions involved in a decision of whether or not to place such a child away from home, and suggests sources of help with planning for his care.

CAMPS FOR DELINQUENT BOYS; a guide to planning. George H. Weber. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 385. 1960. 61 pp. 25 cents.

Warning against the idea that work camps are a panacea for the vast and complex problem of juvenile delinquency, this publication discusses their place in a delinquency program, the type of boy for whom they might be most helpful, the services necessary to a constructive treatment program, camp administration, the elements of an adequate physical plant, and types of staff needed.

RESEARCH RELATING TO MENTALLY RETARDED CHILDREN. No. 1 of a series, Research Relating to Special Groups of Children. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960. 92 pp. 35 cents.

More than 450 research projects on mental retardation, all reported to the Children's Bureau Clearinghouse for Research in Child Life since 1949, are listed in this publication. Among the headings are: etiology; growth and development; and special education.

DIRECTORY OF PUBLIC TRAINING SCHOOLS FOR DELINQUENT CHILDREN. George H. Weber. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960. 66 pp. Single copies available from the Bureau without charge.

The sixth revision of this list of training schools provides up-to-date data on 177 State training schools, camps, and reception-diagnostic centers serving delinquent children committed by courts in 49 States, the District of Columbia, Puerto Rico, and the Virgin Islands.

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Family Health Services in Teheran

Rehabilitating ADC Families

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◀

MOTHERS AND CHILDREN waiting their turn at the children's clinic of the American Joint Distribution Committee's hospital in the Mahalleh, or Jewish quarter, of Teheran, Iran. How the committee reorganized its health services for children to introduce a family health program is described on page 83.

◀ *the authors*

Helen Cohn left the American Joint Distribution Committee this March to join the staff of the Harvard School of Public Health. A South African, trained in nursing in South Africa, in midwifery in England, and in public health at Harvard, she has worked with the JDC in Iran, Morocco, and Tunis, and with the World Health Organization in Israel. For 12 years she was nursing director at the Institute of Family and Community Health in Durban.

Dr. Austin W. Matthis, who was health officer for Imperial County, Calif., when the project described in this issue was initiated, has since become health officer in the Sacramento City and County Health Departments. Dr. Belle Dale Poole, who has been with the California State Department of Public Health for the past 13 years, was previously in private practice as a pediatrician. Gwendolyn Beckman, who has been with that department for the past 16 years, received her social work training at the Simmons School for Social Work and the University of California at Berkeley.

Annie Lee Sandusky was on leave of absence for 3 months from the Children's Bureau to participate in the Cook County (Ill.) study of families in the aid to dependent children program she describes here. Her specific task was to train the interviewers for the study. Mrs. Sandusky has been with the Children's Bureau for 14 years. Before coming to the Bureau, she was head of the casework department and instructor in casework and child welfare at the Atlanta University School of Social Work.

R. Robert Geake (left), who is studying for his doctorate in education at the University of Michigan in the summer, directs a children's reading clinic at Ferndale, Mich. He also serves as educational consultant and tutor for the Methodist Children's Home Society, Detroit. Wallace M. Lornell (right), a graduate of the New York School of Social Work, has been in his present position for the past 5 years. Previously he was cottage life supervisor at a children's home in Lake Bluff, Ill.

Elizabeth K. Radinsky has spent her entire professional career in the foster care field. She was director of casework for Jewish Youth Services in Brooklyn from 1940 until the agency's merger a year ago with the Jewish Child Care Association of New York, where she now heads the foster home-care and foster family day-care programs. Mrs. Radinsky holds master's degrees in social work and social science from New York University and the University of Pennsylvania, and a certificate in the advanced curriculum of the Smith College School of Social Work.

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A FAMILY HEALTH PROGRAM IN TEHERAN

HELEN COHN
Formerly Public Health Nursing Consultant, American Joint Distribution Committee

FOUR YEARS AGO the American Joint Distribution Committee, a Jewish health and welfare organization widely known as the JDC, initiated a family health program in the Mahalleh of Teheran, Iran. The Mahalleh is that part of the city where the people are poor, live in overcrowded conditions, and are provided with the least adequate of the city's amenities. It has a population of approximately 14,000, and, although known as the Jewish quarter, about 6 percent of its inhabitants are Moslems. The people live at peace with each other, and the JDC's health services there are available to all elements of the population.

Since 1950 the JDC has worked in conjunction with a local Jewish committee known as the Kanoun Kheir Kha, a group of people with a real sense of responsibility for the poorer section of the community.

The program in 1957 included:

1. A hospital comprised of a 12-bed maternity ward and a 20-bed pediatric ward, adult and pediatric outpatient clinics, and a dental clinic.
2. A maternal and child health center including prenatal and well-baby clinics some distance away from the hospital. Dietary supplements for needy children and layettes for the newborn were distributed from this center.
3. A school health program providing care and referring sick children to the hospital.
4. A sanitation program concerned with hygiene in the homes, schools, and shops.
5. A nursing school for training nurse aids for the program's services.

Although these services were administered as individual units, there was some coordination by virtue of their belonging to the same agency. Reassignment of nurses took place according to staff requirements; patients were referred from one service to another; school children to the hospital, prenatal patients to the maternity ward, and in some instances, babies from the well-baby clinic to the hospital's pediatric clinic. Case records, however, were duplicated in each service and there was no coordinated planning for the patient.

Over the years the JDC had helped to open additional services as needs became apparent, and insofar as it was possible to meet them. Prenatal care, supplementary feeding and immunization, as well as medical care for the sick, had lowered the infant mortality rate, reduced the incidence of communicable disease, and increased the people's understanding of the use of health services. These were dramatic changes in the standard of health in the community. But there remained much to be done.

A visit to the Mahalleh revealed the hazards of the environment to the healthy growth of children. In addition to the overcrowding in homes, there was a lack of understanding on the part of the people of hygiene and healthy habits. Attendance at the pediatric clinics was largely of children with diseases arising from—or closely related to—their family and environmental conditions, so that neither prevention nor treatment of such diseases could be properly achieved in the clinic alone. Furthermore, it was often the least informed mothers who did not come to the doctor or did so only when their children were desperately ill.

The JDC questioned whether it was not possible to make the services more far reaching and more fully available, and to relate more effectively environmental and social factors with the health of the mother and child. Therefore, in 1957 an attempt was made to reorganize the services on the basis of a family health program.

What It Is

A family health program is an integrated public health and medical care program in which the family, rather than the individual, is the unit of practice. It aims at promoting the standard of health of the total family so that each individual enjoys the advantage of a healthy environment. Thus the child is seen, not as one of a group of well babies or sick babies, but as a member of a family, and his care includes the "treatment" of the environment, both physical and social, on which he is dependent for healthy growth and development. Similarly, the pregnant woman is not seen as one of many pregnant women in a prenatal clinic, but as a member of a family where the health of husband and children has such influence on the mother's health and on the coming baby's, that they too are the concern of the doctor and nurse giving maternity care. The family is chosen as the unit of practice because its members share a common environment and common resources, and because of their dependence on and responsibility for each other.

A program aimed at promoting the health of families requires that a team of health workers be assigned to a group, or neighborhood, of families and learn to know their state of health and need of health services. A variety of professional skills is required to meet the complexity of family conditions relating to their health.

The program introduced in the Mahalleh was not a comprehensive family health service. The team lacked social workers, health educators, and other professional workers to adequately meet the problems emerging from a closer knowledge of the family. The agency lacked the resources to raise the economy of the family to a level more conducive to health, or to provide the community with basic environmental services. The program was, nevertheless, family centered in its reorganization of existing maternal and child health services, in its focus on family factors relating to health and disease, and in its reorientation of staff to a coordinated family approach.

It is the purpose of this paper to outline the type of staff training which preceded the introduction of the program, to discuss the organizational changes which were effected, and to comment on the function of the nurse in this setup.

Training

Lectures and discussions were held before the start of the program and were attended by nursing and sanitation supervisors, specialists who would be involved in the program, i.e., gynecologist, dentist, and so forth, and the staff of doctors, nurses, and sanitarians who would constitute the "teams." These latter and their functions at the time included: three physicians, one in charge of the Maternal and Child Health Center, two in pediatric outpatient clinics; eight behyars (public health nursing assistants with 2 years' basic training and a brief orientation course in public health) working in the prenatal and well-baby clinics; three sanitarians in a home environmental program; and four admission clerks from the well-baby clinic and the hospital outpatient clinic.

Inherent in the presentation of the new type of organization was the redefinition of the functions and a reevaluation of the practices of every individual in this group. Not only did the participants represent a number of hitherto unrelated services but they were people of such varying levels of qualification and status that it was questionable whether they could sit together in a class or discuss their functions together. Furthermore, it was clear to them from the beginning that they were about to embark on a form of practice, which, in Teheran, had all the hazards of an experiment.

The introduction of the family health service was dependent on this group's understanding of new principles and willingness to put them into practice. The course was therefore designed in such a way as to provide abundant opportunity for discussion of the program and for arriving at conclusions which would motivate the members of the group to participate wholeheartedly in the reorganization of the service and the redefinition of their functions.

Eight 2-hour sessions of lecture and discussion were held. For example, a lecture on the subject of family structure and the related growth and development of the individuals in the family group led to discussion of the influences determining the health of an individual, of the importance of understanding these influences and recording them, and of the appropriate methods for doing this. Thus the need for a family census card, showing family structure and relationships and the best method of obtaining this information, was fully discussed.

Similarly, a lecture on family resources in relation to individual needs led to a discussion of the importance of developing the kind of relationship between the worker and the family which would permit guidance in the home in respect to such intimate details as the use of money or the distribution of food. This called for skills in understanding the dietary requirements of people at different stages of development and the different demands of individuals on the family's common resources.

A lecture and discussion on the growth and development of the child within the family revealed how procedures had to be modified to put an accepted theory into practice. A brief résumé of the progression of this discussion follows:

> The concept of "normal growth and development" of the child is based on physical, mental, and social standards. Deviations from the normal may result from inadequacies in the family's ability to give care, hazards in the environment, or a defect with which the child is born or which he acquires. Promotion of healthy development and prevention of disorder may be achieved by securing favorable conditions in his family and environment, by reducing the hazards to which he is subjected or increasing his resistance to them.
>
> When deviations occur, the aim of the treatment is to return the child to a pattern of growth normal for himself. Whether the procedure of the service is labeled promotive, preventive, or curative, its aim is to maintain the child in the best possible course. This can be achieved better by one doctor who knows the family, its resources and inadequacies, and knows the child, his growth pattern, resistances, and susceptibilities, than by two doctors, one of whom, seeing the child only in sickness, is unable to relate him to the overall picture. The well-baby doctor, therefore, and the doctor of the pediatric clinic should be merged into the one "family doctor."
>
> In the community to which a team is assigned, there are some children who are well and some who are sick, the same child is sick one day and well the next. Therefore, it becomes difficult to define what is meant by the "well baby." Few babies in this community reach optimum standards of health. Absence of communicable disease or fever might qualify the child for the well-baby clinic, but would this exclude the child with a beginning diarrhea, a discharging ear, or impetigo? Is the underweight child, in need of vigorous nutrition therapy, a sick or a well baby? Should the mother be expected to make the decision as to which clinic is the best for her child? Should not the well-baby clinic and the pediatric clinic be merged into one clinic for the promotion of healthy growth and development?
>
> Bringing well and sick children together raises problems of cross infection in the waiting room and doctor's office; but this is no more of a problem than in the pediatric clinic where children are known to suffer from a variety of infections, or in the well-baby clinic where hidden infections exist. Precautions should be taken in all situations.
>
> A more serious problem might be maintaining health education and immunization in a combined clinic which is likely to become crowded with sick children. However, education of mothers is frequently more effective when they are anxious about their sick children than when their children are healthy.

Convinced of the importance of a coordinated approach to the growth and development of children, the group was ready to relinquish the well-baby clinic and to plan for what came to be known as the "area session."

Staff Assignments

Having studied the implications of family health, the group met to plan methods of introducing new procedures based on the principles they had accepted.

A map of the Mahalleh was prepared and divided into three geographic "areas," each comprising approximately 470 families. The staff was organized into three teams, each with responsibility for one area; that is, one-third of the Mahalleh. Thus the doctor and behyars previously engaged in the child health center and those from the pediatric clinic would now undertake health and medical care for all the mothers and children in their area.

Each team comprised the family doctor, two behyars and one sanitarian, each behyar being responsible for half an area, or 235 families. Supporting the three teams was a staff of supervisors, nurse aides, and health recorders.

Team schedules were arranged, giving time to area sessions attended by doctors and behyars, home visiting by behyars and sanitarians, and team meetings for discussion of reports and evaluation of the service. The two behyars in the team alternated between visiting in the homes and attending the area session, each making appointments with her families to visit the doctors on the days she would be there. In addition, both behyars attended a weekly prenatal session with the gynecologist for patients from their area. The three teams met together once a week to discuss matters related to the community as a whole.

Records prepared for the program included census cards, birth and death notifications, simple case clinical cards on which to record examination of children whether sick or well. An environmental investigation record was designed for the sanitarians, and a community sheet on which the nurse showed the scatter of their home visits to families.

During the period of lectures and discussions, alterations were being made in the hospital to increase beds for maternity care and accommodate the area sessions and records of the family health program.

Family Health Program

When the family health service began in August 1957, a fundamental change in approach had taken place in the staff. In addition to having developed an awareness of the significance of social and economic factors they now considered as the object of their work, not only the patient who attended the clinic but the area to which, as a team, they were assigned and in which they were responsible for seeking out the health needs of the families.

The behyars and sanitarians visited every family in their area for census taking and home sanitation investigations. Meanwhile the doctor, with the alternate behyar, examined patients at the area sessions. Neither the home visiting nor area sessions were confined to surveys, but included treatment, advice, and many kinds of assistance. The families soon learned to know their own team, their session's days, and when to expect their behyar or sanitarian to be visiting in the area. When asked their address they gave not only their street and number but also their area.

Thus the team gained a picture of its community: the number of pregnant women, young babies, and newborn; in which homes the environment was a hazard to health; the families which for economic or emotional reasons could not provide adequately for their children without assistance; what the diseases of high frequency were; the problem of communicable and chronic diseases; and recurring problems in child rearing.

Community Programs

In addition to planning care for individual families, community programs were developed on the basis of the recorded information. Health education on the prevention of common winter accidents was one. Family care in relation to the prenatal program was another. Priorities emerged; one example calling for special planning was the care of "the underweight baby."

In regard to this last, the staff decided first to define what was meant by "underweight." This led to consideration of birth weight, prematurity, expected weight gain, loss of weight resulting from acute disease, and failure to gain weight as a result of prolonged underfeeding. Consideration was then given to ways of preventing or treating each of these factors, and the role each team member would play in this.

Every case of an underweight baby was recorded on a specially designed card, for inclusion in the special program. Causes for the condition were sought by the doctor in an examination of the baby to ascertain the presence of disease; by the behyar through assessment of the diet and the care at home; by the sanitarian through examination of the environment for sources of infection. The team discussed their findings and the doctor directed the program of treatment and of continued observation.

This program achieved marked improvement in the growth of underweight babies. In addition, it had important educational value for the staff and brought to the attention of parents the variety of factors related to the development of their children.

Another "priority program" was the prevention and early treatment of enteritis, in which the team had related functions and planned their work together; again the family became aware of the many factors in the home relating to disease.

Whether a program was based on the care of pregnant women, or arose as a priority such as enteritis or accident hazards, the approach was always to the family as a unit and the aim was to help the family to undertake responsibility for its members. In this regard the relationship which developed between the behyar and her families was of major importance.

The Behyar

As nurses in the prenatal and well-baby clinics, behyars had some knowledge of public health routines; they could weigh babies, do routine immunization, and distribute milk and food supplements. They had also had preliminary training as hospital nurse aids. Their role had been that of assistant to the doctor and they executed his orders under his supervision at the center. In the family health program the behyars attended area sessions with the doctor, but as much as half of her time was spent in the homes, keeping close contact with all the 230 families in her half-area. Like many of the staff, the behyar herself had lived most of her life in the Mahalleh and the conditions were not new to her; as a member of the team with clearly defined functions, she saw it now from a new point of view.

The Mahalleh is drab and overcrowded; it has a poor water supply and inadequate garbage disposal. Narrow streets which wind between the high walls throng with women and children and street venders. Small doors in the walls lead to courtyards around which the houses are built, all their windows and doors opening onto the courtyard.

On entering a courtyard the behyar encounters a group of women, young babies, and children, and perhaps one or two men, washing, or talking, or just idling in the sunshine. She knows the families who share this courtyard and can tell which children belong to which mother, and whether the father is at home because he is sick or because he has lost his job. She knows that a particular baby is due to be vaccinated, or that a mother is pregnant and should be getting milk powder to supplement her diet. She knows that the small bricked pool, a feature of every courtyard, is common to them all. They wash their clothes and their dishes in it, use it for cooking, and children may drink from it; the very young may fall into it, and many have drowned. She knows that an infection in any one of these families is a hazard to them all, but that they will help each other as good neighbors in time of need.

Knowing these people as a "courtyard group" the behyar knows them also as family units. She knows that a family of five or six people lives here in two small rooms where they must all sleep, eat, dress, and store their belongings; that the adolescent daughter has no place to hide her private possessions or entertain her friends; and that the parents have no place for a private discussion and no possibility of isolating a child with an infectious disease.

Here in the home the behyar talks to the mother about her child's diet and his general progress, and the mother discusses problems of her children, her husband, her poverty, her relationship with an adolescent daughter or a sick child of a neighboring family. Whatever the problem is, it relates to health and the knowledge of it demands action on the part of the behyar.

Considerable responsibility rests on the behyar both in her visiting in the homes and as a member of the family health team. She must be skilled both in the nursing care of children and in observation and interpretation of home conditions. Faced with a variety of family problems, she has to know the extent and the limitations of her function. Certain routines give her assurance in her work; she has standardized criteria for referring and reporting. But her understanding of the significance of her observations has to grow with experience and in discussions with the team.

The behyar's chief function is to promote the health of families through an educational approach applied equally to mothers of sick children and to mothers of healthy babies. Being accessible to the families for all their nursing needs creates countless opportunities for her to develop the kind of relationship which permits her to influence customs. Her caseload includes home care to sick children, routine neonatal visits, and diet advice to pregnant women. But in all cases her goal is to foster in the family, rather than to retain for herself, the responsibility for the care of the individual. She visits to observe the patient's progress and to assist the family members in caring for him, giving them an understanding of his condition as well as the satisfaction of bringing him back to health. Thus the care of the patient at home implies not only care within the family but care by the family.

The Hospital's Role

The hospital became an integral part of the coordinated health and medical program. However, the close supervision and detection in the homes led to early diagnosis and treatment of gastrointestinal and upper respiratory infections, and thus frequently prevented disease from progressing to a degree which required hospitalization.

Children from the area were admitted to the pediatric ward only after it was ascertained that they could not be nursed at home. Those admitted, therefore, were children in whose families there were special needs to be met and environmental conditions to be treated. The team doctor was responsible for the admissions from his area, and supervised the hospital care of his patients. The area behyar visited the child in the hospital, and she and the sanitarian visited his home while he was away.

Every pregnant woman in the area was known to the behyar and was encouraged to enter the maternity ward for delivery. In the 3 years following the initiation of the program, over 99 percent of the deliveries in the Mahalleh did take place in the hospital, all of which had been preceded by prenatal care at the clinic and visits at home by the behyar. In each case, the team doctor examined the new baby in the maternity ward and the behyar visited the mother at the hospital and arranged the date of the first home visit after discharge.

Association between the hospital service and the family health service has helped the hospital staff appreciate the influence of home and family factors on their patients.

Some Results

A number of recorded factors are available for periodic evaluation of the family health program. Records show, for instance, changes in the incidence of certain significant diseases, in the use made of health and medical services, in mortality rates and in the number of underweight babies. Changes in the environment such as the protection of the water supply, and an understanding of the etiology of disease—expressed in the adoption of healthier habits and a more enlightened approach to child care—attest to the effectiveness of the program's health education techniques.

One year after the introduction of the program, certain impressions were noted:

- The staff worked with new interest and at a higher standard. Nurses and sanitarians, engaged in a coordinated service with each other and with the doctors, developed a sense of responsibility and pride in their work.
- A low incidence of enteritis, represented a marked change over previous years.
- Routine immunizations were adequately carried out.
- A mutual confidence and respect had developed between the staff of the family health service and the people of the community.

Today's quick recoveries from mental illness effected by new treatment methods pose questions regarding the care of . . .

CHILDREN OF DISCHARGED MENTAL HOSPITAL PATIENTS

ELIZABETH K. RADINSKY
Director, Foster Home Division, Jewish Child Care Association of New York

HOSPITALIZATION of a mentally ill parent is one of the most frequent precipitating causes for placement of children in foster care. For example, diagnosed mental illness has been reported in 62 percent of the families of the children in the care of the Jewish Child Care Association,[1] a voluntary child-placing agency in New York City. In most instances, hospitalization of the parent, usually the mother, has been the reason for placement of the child. In recent years more intensive mental hospital treatment, including the use of tranquilizing and other drugs, has made for unexpected or accelerated discharge of many parents from mental hospitals. Our experience at the Jewish Child Care Association has led us to believe that the impact of these discharges on the children who have been placed in foster homes needs intensive study.

We are in a period of a changing emphasis in social work generally, broadening the scope of our concentration from the individual to the family as a unit. Those of us who do foster home placement have been influenced by this change and have been reexamining our thinking about the place of the parent in the life of the child who has been placed away from home.

There was a time in foster care, not so long ago, when foster home placement was regarded as a panacea for children's problems. We regarded separation from the "highly questionable" family to be the best solution for the child who had been exposed to social pathology, mental illness, or both. We may have been aware of the manifold reasons—including excessive feelings of guilt or inadequacy—that contributed to his parent's withdrawal from parental responsibilities, but we felt no responsibility to the parent to help him handle these feelings. We either actively and deliberately discouraged the parents from visiting the child whom we had placed in foster care or, if the parents themselves did not sustain contact with the agency or their child, we made no effort to bring them back into the child's life. We overlooked then what we are now realizing sharply and clearly—that for the child the parent is present whether or not he is actually on the scene.

Despite the changing focus in our work with parents, we were still not ready for the dramatically sudden discharge of mentally ill mothers from hospitals which began to occur a few years ago, nor for the resulting effects on their children whom we had placed in foster care. Experience in the past with children in placement precipitated by a parent's mental breakdown had accustomed us to expect that the prospect of the child's reunion with his family was slight and that the duration of placement would be long. Consequently, our initial reaction to the sudden discharge of parents from mental hospitals was one of concern for the child, lest his way of life in the foster home be disturbed and lest he be returned home prematurely. As practitioners we had to reorient and adapt ourselves to this new phenomenon with its impact on ourselves, the children, and our planning. The following, our experience with the Brown family, illustrates this point:

We were in the process of working with Mr. Brown on the need for a plan in regard to himself and his son Louis, age 8, who was living with a foster family. The reports from the

State hospital as to the likelihood of Mrs. Brown's recovery from her mental illness of 7 years' duration were repeatedly unfavorable. In the course of our planning, we interviewed Mrs. Brown's mother and learned of a plan for discharging Mrs. Brown to her. This seemed so unlikely in view of very recent unfavorable reports from the hospital that we questioned the credibility of her statement. However, we subsequently learned that a 6 months' course of thorazyne treatment had resulted in such a dramatic change in Mrs. Brown that she was now ready for discharge. Even before we had word from the hospital about this, Louis' father told us, rather fearfully, that he was expecting his wife home.

Mrs. Brown's discharge was one of a succession of similar discharges which catapulted us into recognizing that mentally ill parents were no longer to be discounted, but had to be reincorporated into our total concept of work with the child and his family.

Almost always, discharge of the parent from the hospital is closely followed by a request for discharge of the child from placement. Often the child, at the time of placement—and for a long time afterwards—showed signs of deep emotional disturbance himself—the effects of having lived with a psychotic parent and of the kind of family disruptions that occur in families with a mentally ill member. Louis Brown had shown such signs:

Louis Brown had come into the care of the agency when he was 5 years old, after 3½ years of being shunted between the home of his nervous, highly strung, overprotective widowed maternal grandmother and that of his maternal aunt. In his aunt's home there was constant quarreling and bickering among the adults as well as conflict between Louis and two older cousins.

Mr. Brown, a depressed, diffident individual who had been brought up in an institution from infancy because of the hospitalization of his mentally ill mother, became concerned with the disturbance his son was showing. When he learned that the prognosis for his wife's recovery was unfavorable, he insisted on his child's placement in foster care despite the determined opposition of his wife's relatives.

Louis, extremely shy and fearful, suffered from stuttering and a constant, hacking, nervous cough. Initial psychological tests indicated that he was intellectually superior, but had inner fears and anxieties which were affecting his mental functioning. His first year in placement was difficult, but the following 2 years brought steady improvement. Gradually he showed less evidence of having fears; he acquired friends; he became able to assert himself with his foster parents and foster brother and he became a leader in his class.

Louis' maternal grandmother, an important person in this family, exerted a controlling, domineering, and destructive influence on Louis' mother. When Mrs. Brown became accessible to treatment, the hospital tried to help her become more independent of her mother, but did not succeed. An added stumbling block to these efforts was Mr. Brown's passivity.

Even after discharge, Mrs. Brown was guarded, suspicious, fearful, and uncommunicative. Both she and her mother regarded her discharge from the hospital as a sign of total cure and readiness to care for Louis. Despite our agency's attempt to work with Louis' grandmother during Mrs. Brown's hospitalization, she continued to regard us as the authority responsible for her daughter's continued hospitalization and, through the child's placement, of her son-in-law's freedom from responsibility.

Mr. Brown, who received intensive casework treatment after the child's placement, had slowly achieved trust in the agency's genuine concern for his child and himself. He had begun to take a more active role as a father. Although he could not withstand the combined pressures from his mother-in-law and wife sufficiently to be able to defer asking for the boy's return, he was able to participate in the planning for this with the caseworker. This allowed a span of time after Mrs. Brown's discharge from the hospital before the child's return home during which the mother could visit the boy for gradually lengthened periods of time in his foster home, and he in turn could make weekend and holiday visits to his parents. Thus Louis had an opportunity to become acquainted again with his mother before he went to live with her, and Mrs. Brown had a chance to try, with the caseworker's help, to become accustomed to the fact that the infant she had left behind when she was hospitalized was now an 8-year-old boy.

After Louis returned home, his caseworker continued to work with the family for a year even though Mrs. Brown was as suspicious of her as ever. Because of Mrs. Brown's suspiciousness, the caseworker's contacts with Louis had to be in her presence, an arrangement that was frustrating to the child. In the foster home he had been allowed time with the worker alone, and was well aware that the worker also had individual interviews with each of his foster parents and with his own father.

Mrs. Brown also frowned on the worker's having separate interviews with Mr. Brown. For her, the supervision provided by the agency in the interest of her child was an evil to be lived with—the price of having her child discharged to her.

Louis' area of continuing gratification was at school. He learned, to a degree, to circumvent and control his mother as she repeatedly tried to impose her fears on him. He accepted his mother's prohibition against having friends visit him at home and he developed a technique of ignoring his mother when she encountered him with his friends on the street. When he was supposedly at the library, he was actually in the park playing with his friends. During Open School Week he arranged for his mother to visit in the classroom and for his father to come for a conference with his teacher. He did not ask to visit his foster parents, but did manage, with his father's help, to communicate with them.

On the basis of our analysis of Louis' needs and our understanding of the family situation, we would have preferred for Louis to remain with his foster family until he was 2 or 3 years older. This would have given him further opportunity to utilize the good environment of the foster family and the agency's treatment services to free untapped potentialities which had been dammed up by his earlier traumatic experiences.

Long-time Care

Some situations call for the protection of children in foster care for the duration of their childhood. However, even in these situations the parents have significance for the children, and the family as a whole for each member of it. We have sometimes found it necessary to control and supervise the parents' visiting of their children by having the visits held, by appointment and, in the presence of the caseworker, in our office. Even so the visits become something of a family get-together.

Some parents can be helped to accept a curtailed role as parents for the sake of their children as well as for themselves. They learn to understand that the agency has to take on the child rearing responsibilities as well as treatment to give their children as much opportunity as possible for corrected development and growth. Many parents who did not in their own childhood have the opportunity for healthy personality development want it for their children and can participate, in varying degrees, in a plan to let them have it. Such parents were the Stones.

Sam, the oldest of the three Stone children, aged 7 to 15, told us that his father had called him to announce that they would be going home because the mother had been discharged from the mental hospital. The Stone children had been placed in foster care by us 3 years before, their placement precipitated by their mother's hospitalization.

Mrs. Stone had never been equal to the responsibilities of motherhood. She had remained in bed most of each day, neither bathing her children nor preparing food for them. Mr. Stone, a man with a dependent, immature personality, also spent most of the day sleeping because he worked at night. The two older children were sent to the maternal grandparents on awakening. The youngest was kept tied in the crib each day until the father awoke and took him to the grandmother's home.

Held responsible for his wife's condition by her family, Mr. Stone had resigned himself to this pattern of living until his wife had an acute psychotic episode. This episode precipitated the placement of the children in foster care, but by then they were so severely disturbed that no foster family home could contain more than one of them. They were therefore placed in different families. In addition, each required psychiatric treatment, which was arranged for by the placement agency.

Immediately after the mother's release from the hospital, Mr. and Mrs. Stone demanded the return of their children. This was not surprising since they had regarded the mother's hospitalization as the reason for the children's placement. The agency and the hospital's after-care clinic were united in letting the parents know that returning the children home would involve grave risks to both the mother and the children. Mr. Stone was encouraged to withstand his wife's pressure for the children's discharge from the agency and agreed to a plan of continued foster care for them. The children were helped to understand and to accept the nature of their mother's illness and their need to remain away from home. During the parents' visits to the children, the worker's presence tempered the interaction of children and parents, to the benefit of all.

In this case if we had not been able to establish sufficient rapport with Mr. and Mrs. Stone to keep them from pressing for their children's return, we would have considered it our responsibility to take legal steps, with the support of the after-care clinic, to prevent the children from being returned home and to keep them in foster care.

Seeing the Family Whole

The following experience provided us with a serious lesson in the importance of diagnosing the family as a unit.

The Rose children, 3-year-old Jane and 22-month-old Paul, had been placed in foster care at their father's request at the time of their 28-year-old mother's third attack of mental illness. In the history of violent marital discord that preceded Mrs. Rose's mental break, Mr. Rose had played a significant role but casework efforts with this youthful, immature father during the year of his children's placement did not appreciably alter his failure to comprehend his share in the responsibility for the disturbed relationship in the family, or the implications of his wife's illness.

After receiving drug treatment and psychotherapy in the hospital, Mrs. Rose was remarkably improved. Being home from the hospital, albeit on convalescent status, meant to her having the children again with her. Therefore, she and her husband immediately pressed for the children's return to them. Both the medical and social service staff of the hospital and the representatives of the agency, in joint conference, recognized the fact that returning the children involved a risk. But the psychiatrist who had treated Mrs. Rose pointed out that "being the mother" had been the prime motivation in her recovery. Consequently, a family service agency was enlisted to provide the Rose family with a specially selected homemaker, while our agency, as the agency which had worked with the children and their father during placement, continued to visit the children regularly after they returned home. To avoid confusion for the mother, the family service agency agreed to let the foster-care worker supervise their homemaker.

Despite the coordinated efforts of the two agencies, it became increasingly apparent in the following 3 months that these children should not remain at home. Mrs. Rose was unable to function as the mother but would not let the homemaker substitute for her in this capacity, even in giving the children their meals. She would not take the children to the playground and would not permit them to go with anyone else. The homemaker left, since she was not permitted to be helpful, and the situation worsened.

In bursts of uncontrollable temper, Mrs. Rose would beat little Jane, who had become angry and destructive in the brief period since she returned home. Paul was no longer the happy, smiling baby he had been in the foster home; and the father neither carried his own responsibility in the home nor in any way offset the effects of his wife's disturbed behavior on the children.

Since Mr. and Mrs. Rose refused to consider voluntarily placing the children again, our agency, with the hospital's support, enlisted the services of the children's court to bring the children back into placement. In a joint interview with the hospital social worker and our worker, the parents were advised that the court was being brought into the case for the protection of themselves and their children.

By letting the parents know in advance of this plan and the reasons for it, we were able to avert their opposition to it and at the same time convince them of our concern for the entire family.

In this case we lost sight of diagnostic data important to definition of the family as a unit. The great improvement of the mother during her hospitalization, attributed in large measure to her expectations of resuming her role as mother, had dimmed our awareness of her history of basic personality disturbance and recurring mental breakdown. Caught up in the desire to help the children through reunion of the family, our agency had permitted our doubts about how this would work to be submerged in the hospital's explanation of the motivation in the mother's improvement.

As a visiting father and a visiting husband, Mr. Rose had been concerned and responsible. In his own home, however, he had failed in his everyday responsibilities. He had been ineffectual as a husband and father before the children's placement and after their discharge. He could not accept the implications of his wife's illness nor could he comprehend the risk to his children of the family's premature reunion.

Mr. and Mrs. Rose needed time to live together as husband and wife before assuming the additional responsibilities of parenthood. Our agency, with the support of the hospital, should have made this clear to the couple, for their own as well as the children's sake.

With the children back in foster care, it is now our task to help these two young people who want to be good parents, but are caught in a struggle with their own individual problems and with their relation to each other.

Knowing the Family

The child-placing agency is handicapped in grappling with the question of whether a child should return to a parent recently discharged from a mental hospital, because it does not usually know the family as a unit. Often the return of a child's mother from the hospital affords the placement agency its first opportunity to meet her, since the actual planning for placement may have occurred after her hospitalization. There are, fortunately, guides that can help us build such a picture from the parts we do know. We have had the opportunity while the child was under our care to get to know him and his needs. We have seen the father as a visiting parent and know something of the quality of his fatherhood from the degree of concern he has demonstrated and from the way he has met his specific responsibilities in connection with the child and the agency.

Usually we must rely on the hospital's diagnostic findings for our knowledge of the mother, but we can supplement this by meetings with her in our office or at her home after her discharge and by observing her behavior and her attitudes toward the agency and toward her child during her supervised visits with him while he is still under foster care. Later, planned visits of the child to his own family for brief or overnight stays, depending on the age of the child and his understanding of the meaning of the visits, can contribute further diagnostic and prognostic clues. Thus on the basis of what we learn from our own observations and what we can learn from the hospital after-care clinics, we must make a diagnosis of the family unit in order to reach discharge plans that will be sound for each child.

In some families such plans may have to be different for each child. What might be good for one child might be bad for his brother or sister. The case of Morton and Ann White illustrates the significance of differential diagnosis within the same family.

The White children were admitted into care at the age of 7 and 3, respectively, to make possible their mother's voluntary admission to a private mental hospital. This came after the family had received a year of casework help from a family service agency to which the parents had first gone because of Morton's disturbing behavior. These parents, young people of good intelligence, had both grown up in homes from which their mothers were absent because of mental illness. Neither was prepared for the responsibilities of marriage or parenthood. Almost as soon as Morton was born, a year later, they took divergent attitudes toward him. The father was punitive and hostile; the mother overprotective and inconsistent. Neither was able to provide him a nurturing emotional environment.

On the other hand, their attitudes toward their second child, Anne, born 4 years later, were harmonious and in sharp contrast to their attitudes toward Morton. Both gave Anne the

kind of tenderness and warmth which they had not been able to give to Morton.

Because of the different kinds of experiences these children had had at home and the important differences in the parental relationships to them, we made the decision to separate them while they were under our care. Morton was placed with a foster family chosen especially for its capacity to tolerate and care for a deviant child. Anne was placed in a regular foster family home.

Mrs. White returned home 10 months after the children were placed. At the placement agency we called together her psychiatrist from the hospital, the psychiatrist who in his private practice was treating Mr. White and our own psychiatrist who was treating Morton. The plan that evolved from this conference was discussed with the parents, and agreed to by them. This was first to allow the parents a period of readjustment without the children; and then to return Anne to them, but to postpone Morton's return, probably until he was past adolescence.

The plan to postpone Morton's discharge was based both on his own needs and on the fact that Mr. and Mrs. White needed more therapeutic help before they could be equal to the difficult responsibility of having him at home.

Morton was relieved to hear that he would remain with his foster family and was able to express his fear of trouble and unhappiness if he returned home. Although he has since made progress in his behavior and in his relationships, he is not yet able to cope with the problems in his family. He enjoys visits with his mother and on some visits he tolerates his sister. Sometimes he asks for visits with his father and at others he rebels against seeing him.

In Conclusion

In our work with children of the mentally ill and with their parents, we are still seeking a balance between our responsibility to the family as a unit, of which we are increasingly aware, and our responsibility for the child as an individual. We must come to terms with our recognition of the significance to the child of his own family, for which there is no true substitute, and our awareness that there are some families that without help cannot provide a healthy environment for their child.

We know from experience that there can be considerable risk in reintroducing into a child's life a parent who has been seriously mentally ill. Caseworkers must be alert to their own feelings in this regard. If they want to serve the child well they must examine the facts and implications of the patient's improvement or recovery in light of the known strengths and weaknesses of each member of the family and of the family as a whole.

Although a placement agency such as ours does not have the legal authority to prevent the discharge of a child from its care unless the evidence warrants court action, we are socially and morally responsible for helping a family recognize the risks, when we see them, in taking their child back home. The mental hospital, on its part, has a responsibility for helping the patient and his family to see the implication of the patient's return home, in relation to his family, the role he expects and is expected to assume, and how much of it he is capable of assuming. The child-placing agency also has to take the mental hospital's evaluation into account when planning to continue to keep the child separated from his family, even temporarily. When the child is returned home, the agency must be responsible for helping him become reintegrated into the family, either by continuing to give him service or through enlisting another agency to work with the family as a unit.

There is one final dimension to this problem which our profession must not ignore. A placement agency that carries the responsibility for the day-to-day care of children has both the opportunity and the obligation to provide treatment for children who show the effects of living with mentally disturbed parents. Our experience has demonstrated that casework services, supplemented by a range of remedial services, can arrest or reverse the destructive effects of an earlier environment of mental and social pathology. Only if the children of such families receive the protection they need and the services that can help undo the harm that their emotionally traumatic experiences have done them can we hope to break the chain of recurring mental illness from generation to generation.

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[1] Federation of Jewish Philanthropies: To serve children best—a study of children in foster care. New York, 1956.

Mobility can be a great asset for the well prepared. It can be the trigger of tragedy for those unprepared to utilize their talents.

James T. Vocelle, Chairman, Florida Industrial Commission, to the 1960 White House Conference on Children and Youth.

A recently completed Chicago study reveals some facts about . . .

REHABILITATIVE POTENTIALS OF FAMILIES ON ADC

ANNIE LEE SANDUSKY
Consultant on Children in Their Own Homes, Children's Bureau

A UNIQUE STUDY of the aid to dependent children program which has significance for the entire public welfare field and particularly for child welfare has been completed in Cook County, Ill. The study grew out of the concern of the board of county commissioners over the mounting costs and criticisms of the program. The commissioners were baffled by the fact that the number of recipients was increasing at a time of economic prosperity; they were concerned because the number of illegitimate children on the rolls was increasing; and they were aware of allegations that many families were receiving ADC who were not eligible. Therefore, they selected a committee of 35 leading citizens to undertake a study of the program. This committee was representative of business, industry, the professions, the press, and the commission itself.

After a period of preliminary study and investigation, the citizen's committee hired Greenleigh Associates, a firm of management consultants specializing in the health and welfare field, to make an independent study of the ADC program, operations, and administration in Cook County. The study was financed jointly by Cook County, the Illinois Public Aid Commission, and the Bureau of Public Assistance, U.S. Department of Health, Education, and Welfare.

A research team representing a number of fields of learning and specialties was brought together by Greenleigh Associates to conduct the study. This consisted of specialists in social research, administration, and personnel, as well as sociologists, psychologists, economists, lawyers, and social workers. These persons worked independently on certain phases of the study or as teams on other aspects.

No part of the study was unrelated to other parts, but for convenience it was divided into six major portions:

1. Analysis of comparative data on the ADC program from 12 other metropolitan areas experiencing in-migration.
2. Appraisal of the statutory basis of the program and of residence and other laws affecting ADC.
3. Evaluation of the administration and operations of the ADC program in Cook County.
4. Analysis of the characteristics of the ADC families and the interrelation of these characteristics.
5. Availability of supportive community resources—public and private.
6. Appraisal of social factors in the community affecting ADC.

Although these parts were largely interrelated and that which we learned from one shed light on other parts, they were carried on almost simultaneously because the time allotted to the study was brief.

Some of the most important results of the study were:

- The findings showed the fallacies in some prevalent misconceptions about the administration of the program and about ADC families, such as ideas that most of the families were newcomers to Chicago who had come for the purpose of getting ADC, that many fathers who were reported as deserting were in the homes, that unmarried mothers had children in order to increase their ADC grants. These misconceptions were found to be interfering with the administration and operation of the program and with adequate financing by the legislature.

- It was learned that to know how a large program of this type is operating, it is necessary to have direct and structured interviews with the recipients instead of relying on case records. Case records were found to be inadequate and frequently inaccurate.
- The families on ADC in Cook County were found to have a high rehabilitation potential which was not being realized.
- Because the Chicago ADC staff is on the whole overburdened and without professional training, the caseworkers frequently fail to identify problems which caused dependency initially and which impede rehabilitation.

Rehabilitation as perceived by the study staff means something more than physical or vocational rehabilitation. It means helping the family to identify and resolve their problems, so that they may become independent or more nearly independent of financial assistance. It means helping the family to improve their physical or emotional health or interpersonal relationships, so that they may live more normal lives, even if they cannot become self-supporting. It means helping to reunite families wherever possible. It means helping parents to give better care and understanding to their children so that they, in turn, may have a more normal life, develop their capacities to the maximum, and achieve personal and economic independence. It also means helping the mother who should not work outside the home see how ADC can help her remain at home and provide her children with the care they need.

Family Characteristics

This article will discuss some findings in the section of the study concerned with the attitudes and characteristics of the families on the ADC rolls at the time of the study and the administration of the program as it affected them. The purpose of this section was to ascertain the strengths and weaknesses of the families, to assess their rehabilitation potential, and to determine what were the factors which most frequently created dependency and which impeded a return to independent functioning. Information was gathered on each family's housing, residency, composition, income, employment and educational history, and attitudes toward employment, dependency, and illegitimacy. In addition, assessments were made of the family's management, child care and training, and emotional and physical health. The information was obtained from the case record and from intensive interviews with the family members in their homes, the latter proving to be the more productive source. The analysis of the data included an assessment of the interrelationship of significant characteristics.

Twenty-two case analysts who were professionally trained and experienced social caseworkers were employed to secure data from a random sample of families on the ADC roles. The sample included 1,103 families, more than 4 percent of all those receiving ADC in May 1960. Of these, 1,010 families were visited. The remainder were dropped from the sample because the case was closed, the family had moved and could not be located, or the grantee could not be interviewed due to illness or other reasons.. The cases in the sample were analyzed in order to determine family strengths and weaknesses and the potentiality for rehabilitation. It is this part of the study that is reported here. The total study has now been completed and the full report can be secured from Greenleigh Associates.[1]

Training and Data Gathering

In the 2-week training period for the case analysts, the main emphasis was to clarify the difference between the use of the interview in the casework process to help the client and the use of an interview to achieve the purposes of the research design. It was pointed out that in the research project. social work knowledge and skills are used to help the client give the information required to carry out the purposes of the study—a different process from the interviewing that is focused on helping the individual resolve his personal conflicts and problems. The case analysts were instructed to suggest to individuals who ask for help with their personal problems that they talk this over with their caseworkers from the Cook County Department of Public Aid.

Each family to be interviewed was sent a letter of notification about the impending visit. The letters had the threefold purpose of protecting the dignity of the families, giving them a sense of participation, and identifying the case analysts. Because of frequent turnover within the agency, ADC recipients frequently did not know their caseworkers and there-

Not all families in the aid to dependent children program are headed by mothers. This disabled father is one of many who has been helped by ADC to keep his family together.

fore the study staff had been worried lest the clients would confuse the case analysts with the agency's caseworkers. The letters, on official stationery of the research firm, explained the fact that a study was being made, outlined its purpose simply, and identified the sender as an employee of the firm. The client was asked to telephone if the time set for the interview was not convenient for him.

The approach to the client was also stressed in the training program. Because of the personal nature of the requested information and its relation to ADC eligibility requirements—such as amount and source of income, and the whereabouts of deserting or putative fathers—the case analyst was to point out early in the interview that no information he received would be revealed to the agency. The recipient was to be told that the information he gave would be put together with information given by other recipients in a report, but that no one would be identified in this. The research firm had made an agreement with the study committee and the agency that no information supplied by the persons in the sample would be revealed to the agency in any identifiable manner.

The training program also included a discussion with the case analyst of attitudes toward illegitimacy in an effort to help him in bringing this subject up during the interview.

An interview outline and schedule for the home visits served as a guide to the case analyst in securing information in the home so that there would be uniformity in method and type of material secured. Having read the case record in the district office before visiting the family, the analyst already knew something about the family when he arrived at the home.

The attitude of the ADC recipients toward the study was a surprise. The study staff had been afraid that the recipients might be suspicious of the case analysts and therefore resistant to talking frankly. None of these fears were realized. The recipients readily saw the distinction between the case analysts and the agency's caseworkers. Many of them expressed pride in having been selected to participate in the study and curiosity about the method of selection, and asked, "How was I chosen?" They clearly wanted to give information and to talk about their problems. Out of the entire sample, only two persons declined to participate. They were not urged to do so.

The majority of the recipients showed a sense of responsibility when they could not keep the appointments, telephoning ahead of time to make a change, or if they were not at home for some reason when the case analyst visited, calling later for another appointment. Some recipients misunderstood the letter and came to the study office to be interviewed.

Rating Method

The completed interview schedules were used as the basis for the analysis of the potentialities for rehabilitation of the families in the sample.

Each schedule was rated on whether or not problems existed in certain areas of the family's life and whether or not there were indications of potential for resolving them. The factors considered were: (1) the employability of the grantee; (2) the possibility of additional income to the family from an absent father or other children; (3) health; (4) child care and training; (5) family management; (6) family disunity; and (7) attitudes toward illegitimacy.

Some of the major factors were divided into subfactors. In employability of the grantee, the following subfactors were rated separately as a method for obtaining the factor's overall rating: attitudes toward employment; health; experience; training; and child-care arrangements.

In determining a rating for attitudes toward illegitimacy, the case analyst took into consideration: the number of children born out of wedlock; the number of fathers in the same family; the length of time of the relationship between the mother and the father; the age of the last child born out of wedlock; the mother's attitude toward having a child born out of wedlock; what she had tried to do about it; and the degree of interest of the putative father in the mother and the children.

The rating on child care and training was based on the case analysts' observation, when this was possible, of the physical appearance of the children, their relationship to each other, and their relationship to the mother or parents. It was also based on what the mother said about such things as: whether or not there were problems in dealing with the children and how she handled these problems; what she knew about their school adjustment; whether she visited the school; what arrangements she made for the care of young children when it was necessary for her to be away from home, and her knowledge and concern about where her older children were.

Thus, in all of the factors, the interrelationship of significant characteristics were assessed to achieve an overall score.

In rating each factor, where no problems existed a rating of zero was given; a problem with good potential for improvement was rated 1; and a problem with little or no potential for improvement was rated 2. Thus the family strengths and weaknesses could be measured. The sum of the ratings on the major factors gave an overall score for the family's potentiality for rehabilitation.

A total family score of zero through 3 indicated a very high and immediate potentiality for rehabilitation and self-sufficiency. A family score of 4 through 11 indicated the presence of serious problems but good potentiality for improvement with help. Families with a total score of 12 through 14 had many problems concerning which the case analysts saw little hope of rehabilitation.

The majority of these families received scores somewhere between 4 and 11. This means that they showed good potentiality for the strengthening of their family life and for using help to achieve self-sufficiency.

Strengths in Child Care

The strengths the majority of these middle-scoring families showed were in relation to child care, training and adjustment, family management, and health, physical and mental. They had problems in these areas but ones with high potential for improvement. On the whole, these mothers gave good care to their children. They showed concern about their welfare and seemed to have hopes for their future.

Many of the families had no problems in relation to child care and training or in family management. However, nearly all of them faced a problem common to most children on ADC—the lack of a father in the home. Some of the mothers expressed worry about the effects of this lack on their children. The eligibility requirement that the parent be absent from the home unless permanently and totally incapacitated discouraged family unity in some cases.

The strengths these families showed in child care is of vital importance when considered in relation to the purpose of the ADC program—the welfare of children. The child's experiences in family living and the quality of care, training, and guidance he receives determines to a great extent the kind of adult he turns out to be. When the great handicaps these mothers were enduring in day-by-day living are considered, the tremendous job they were doing becomes evident. Most of them had to be both mothers and fathers to their children. Though they lacked the emotional support, cooperation, and companionship of a husband, they were managing on less than the minimum income considered necessary for health and decency. Their housing conditions were deplorable and their neighborhoods vicious and degrading.

For the total study, 38.6 of the mothers were not married to the "principal father"—the father of most of their children or of their last child if there were two fathers with the same number of children. Yet most such mothers gave evidence of loving their children. They either had no serious problems in child care and training or showed good potential for being able to overcome the problems they had, given appropriate casework service.

Contrary to general opinion, most of these unwed mothers expressed concern about having given birth out of wedlock, and their guilt, shame, and self-derision was expressed in many ways. In others a show of indifference may have been a defense to conceal their real feelings about this problem.

Some of the unwed fathers showed continued interest in the mother and her children. A flexible agency policy and the provision of casework help to both mother and father might have resulted in some stable marriages. For example:

> Mrs. D, a widow with three children by her husband, has had three children born out of wedlock since the husband's death. Mrs. D and the children's father had made definite plans to marry and this was discussed with the caseworker. However, the father did not think he could support six children—three of whom were not his own, on his income. The

agency refused to supplement the income either by general assistance or by continuing ADC for the three children who were eligible and the marriage did not take place.

Employment Possibilities

In about half the cases analyzed there was little potentiality for employment. Yet most of the mothers said they wanted to work if adequate arrangements for the care of their children could be made. Many of them said they would take a job paying even less than their ADC grant, because, as one mother put it, "children want to feel proud of their parents."

The greatest problem in regard to employability was in arrangements for child care. Most of these families had no resources within the family for caring for the children if the mother were employed. Few child-care facilities were available in the neighborhoods where these mothers lived. Some of these mothers were needed at home all day because of the ages or number of their children. Many said they would worry about the supervision of their adolescent girls and boys if they were employed. Community facilities for the after-school supervision of adolescents were even more scarce than facilities for preschool children.

Lack of employable skills and work experience was a major impediment to the employment of many of these mothers. With vocational training some of these mothers could probably achieve self-support in the immediate future, while others could be prepared to go to work when their children were no longer eligible for ADC.

The majority of these families had no potential for achieving additional income from fathers or older children. In a few families the father was contributing already, was dead, or was receiving disability assistance, and there were no older children from whom income could be expected. In the majority of families the whereabouts of the father was not known.

In well over half of these families there seemed little chance of rehabilitation through the reunion of separated spouses or the marriage of unwed parents. On the other hand, in some of the families there were indications of some possibility that the parents would attain reunion or family stability, such as the father's continued interest in the children, the parents' own efforts to try again to "make a go of it" (although many of these efforts had failed), or the continuing relationship of the unwed mother and father of several children. In some instances, a previous and still legal marriage was preventing unwed parents from marrying. In others, the man's inability to get and hold a job was the reason given by the mother for not considering marriage.

Health

Less than 10 percent of the families with ratings ranging from 4 through 11 reported no health problems, physical or mental, to the case analysts. In the majority of the families there were problems of health that could be improved or controlled with adequate medical care. Others had serious health problems that were either chronic or offered little hope for improvement. Many of the incapacitated fathers were in this group.

More health problems were reported in the interviews than in the data taken from the case records. This may have been due to differences in the questions about health on the two schedules—the one for the case record being confined to chronic illnesses. It may also be that the families' infrequent contact with their caseworkers, the shortness of such contacts when they occurred, and the focus on eligibility determination keep them from mentioning health problems to their caseworkers or the caseworkers from inquiring about health.

Low and High Scores

Although the analysis showed that the great majority of the families came in the middle range of scoring, 2.8 percent had ratings that fell in the range of 3 and under, thus indicating a very high potentiality for eventually achieving self-sufficiency. They were families in which the educational level of the grantee was high school or above. The grantee had good training for employment in today's labor market, or good potentiality for training.

Most of these grantees had had work experience of at least 1 year or more before applying for ADC. Some were now employed and received supplementation through the program, and they had made, or would be able to make, adequate arrangements for child care. Neither they nor the children had major health problems. In these families the fathers were either already contributing to the support of the children or, because of death or disability, were permanently unable to contribute. Rehabilitation for these families could be effected on relatively short range goals.

Mrs. C, 23 years old, who is separated from her husband, has three children, 10, 7, and 3 years of age. A year ago she and her husband attempted reconciliation but failed. Mrs. C is employed as a hotel maid and her wages are supplemented through ADC. Her mother lives with her and cares for the children while she is at work. In spite of Mrs. C's efforts, the family is not much better off financially than if she were not employed. Mrs. C buys clothing for herself and children on the layaway plan as do many other ADC mothers. The 10-year-old girl had to be kept out of school for 1 week last winter until the mother was able to buy shoes for her.

Is there enough incentive for a mother to work if she cannot raise her standard of living by so doing and at least procure the minimum essentials required for health, decency, and a suitable standard of living? If wages and supplementation—except for the expenses of employment—come to no more than the ADC grant, those who work are no better off financially than those who do not.

At the opposite end of the scale were the 3.8 percent of the families with overall scores ranging from 12 to 14. These families had serious problems in all or most of the areas studied, and low potentiality for improvement. The possibility of their becoming employed now or in the future is extremely remote because of their lack of skills and of experience usable in an urban labor market, their low educational achievements, limited mental ability, serious physical and emotional problems, and many children—five or more in each family. These mothers themselves saw no possibility of becoming employed.

In these families, care and training of the children were poor and in some instances actual neglect was evident. But in spite of their problems and limitations, most of these mothers were responsive to the case analysts. They will require support, guidance, and many services in helping them to improve the quality of care provided for their children. Work with them will have to be planned on a long-range basis, with the focus on the needs and problems of the children so that they at least may realize their maximum potentialities and break the family pattern of dependency.

In Conclusion

This analysis indicates that most of the families receiving ADC in Cook County have a good potentiality for improvement and rehabilitation, some on a long-range and some on a short-term basis. While many of the grantees themselves may never achieve financial independence, there is great promise for enhancing the opportunities for their children to receive adequate care, guidance, and training that will lead to their becoming independent, self-motivating, contributing members of their families and communities.

To accomplish this task, agency administration, structure policies, and rules and regulations must be geared to services. Many of the social services needed by such families can be provided within a public assistance agency if it has adequate and competent staff, smaller caseloads, good supervision for workers, and inservice training. Other services must come from other community agencies which provide health and medical care, vocational rehabilitation, psychiatric and child guidance services, child welfare services, day care, and other types of help.

The analysis of the home interview schedules reported in this article is only a small part of the total Cook County ADC study. The complete[1] report should be read for its full significance not only for Cook County but for the aid to dependent children program as a whole.

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[1] Greenleigh Associates, Inc.: Facts, fallacies and future. New York. 1960.

It is not to die or even die of hunger that makes a man wretched. Many men have died. But it is to live miserably and know not why, to work more and gain nothing, to be heart worn, weary, yet isolated and unrelated.

Thomas Carlyle in Past and Present, *Harper & Bros., New York 1843.*

TOWARD SCHOOL ACHIEVEMENT FOR THE INSTITUTIONAL CHILD

R. ROBERT GEAKE
Graduate Student, University of Michigan, Ann Arbor, Mich.

WALLACE M. LORNELL
Resident Director, Methodist Children's Village, Detroit, Mich.

FOR THE LAST DECADE or two, many homes for dependent and neglected children have been sending their children to public schools in the community and have encouraged the children to participate in comunity activities. These moves have been made with a realization that children in group care need as many normal experiences as possible. At the same time, however, the number of children in group care who have school adjustment problems is increasing as the result of a change in the nature of institutional populations. With the growing realization that young children need to be brought up within a family group whenever possible, more and more institutions with a tradition of providing longtime care for young children are responding to requests for shorter term, more specialized care for older children and children too emotionally upset to get along well in a foster family.[1]

This change has meant that the institutional programs are tending to becoming more treatment centered than in the past when their chief function was to provide children with maintenance and care.

School achievement is a vital factor in a child's total adjustment. Many children in group care have a very poor concept of themselves. This self-perception is often improved when the child does better in school and receives better school marks. Our society places intrinsic values on school marks, and children come to equate these marks with real achievement and a measure of personal worth.

Many children in child-caring institutions today cannot adjust in public school either because of severe behavior or learning problems, or both. Consequently some institutions are introducing tutoring on the grounds for at least part of the populations. In a well-planned institution, such classes are geared for remedial work and do not keep children away from the public schools who are acceptable there.

However, much remains to be done for children living in residential group care who are able to attend public school. Many directors of children's homes have felt for a long time that children in their charge do not do as well in public school as their classmates from the community. A recent comparative study of school marks in one children's home confirms this impression.[2] In this study the report-card marks of children living in a children's home who attended four public schools in grades 2 through 9 were collected. Then children living in their own homes were found who could be matched with the institutional children in regard to intelligence, sex, public school attended, and grade level within each school. This study revealed that the children from the institution were underachieving significantly in all academic subjects, though they were performing better in nonacademic subjects, such as music, art, and physical education. Underachievement was defined as a failure to perform as well as would be expected from a child's measured intelligence and the achievement of comparable children.

Causes and Blocks

Some possible causes of underachievement of institutional children in public school include:

- The community values and culture may be drastically different from the child's familiar surroundings.
- Academic school achievement may not have been considered important in the child's home.
- The child's school attendance may have been disrupted by frequent shifts between relatives and boarding homes.
- The child's emotional state may be characterized as acute anxiety with resultant learning blocks.
- The community and the school may be prejudiced against the "kids from the home" because they present problems to the teachers and principal.

This last possibility was strengthened by Hadley's demonstration of the fact that children who are less well liked tend to receive lower school marks irrespective of their actual achievements.[3]

A primary block to helping institutional children to better school achievement seems to be a general apathy in this regard among professional educators and social workers. This may stem from lack of appreciation of the meaning of school marks to children. In many institutions this kind of apathy is supported by the fact that the children's school achievement is nobody's specific responsibility. By default, the public school teacher, probably already struggling with the academic and behavior problems of several other children in her class, is left the task of identifying and stimulating the underachieving institutional child. She may begin the task of working with such a child with enthusiastic optimism, only to find as the weeks go by that little or no progress occurs. Then a sort of hardening of the emotional arteries may set in until even the normal current of academic and social stimulation between teacher and pupil ceases to flow.

Achievement is to be measured against potential, we are sometimes told, and the crude conveniences of A's, B's, C's, D's, and E's, though they must be tolerated, are not to be regarded as valid enough indices of anything to be worth doing something about. Even if this is true the plain fact remains that marks are important to children, and we can be of greater help to children if we recognize this. The report card is the "paycheck" of the school child. The development of ego strength may be directly related to school achievement, of which marks are society's symbols.

What Can Be Done

There are five prerequisites to academic learning, and these need to be assessed individually for each institutional child before he is placed in public school. The first of these is general intelligence and the rather specific abilities of which it is believed to consist. The institutional administrator in planning for the children's education ought, therefore, to insist on more than an IQ score from the psychologist. He needs to know about subtest performances and their implications for level of functioning both currently and potentially.

The second prerequisite is developmental readiness and potential. This includes physical maturation and also the fund of experiences on which the average child who lives at home can draw—experiences which the institutional child may have missed in the sequence of disrupting events that led to his placement. They include such ordinary events as trips away from home, conversation with adults, and opportunity to develop and execute one's own plans in play.

The third prerequisite is freedom from emotional tensions and anxiety blocking, conditions which make learning difficult or impossible for some children. Where anxiety and tension are great, energy which is normally available for learning may be diverted into dealing with emotional conflict. Among institutional children, emotional problems of long standing often continue to trouble the child long after placement in a treatment-oriented setting.

The fourth prerequisite to learning is motivation. The child is motivated to learn only as he perceives himself as capable of succeeding. Children vary in degree of motivation for learning according to their previous experiences of success and failure.

The fifth, and most significant, prerequisite for academic learning is the opportunity provided by an educational program which recognizes the child's needs and includes specific, planned procedures of academic stimulation.

Recognition of a problem is the first step towards a solution. Many modern child-caring institutions have recognized the need for casework service, including psychological and psychiatric consultation, to help the children with their emotional problems, and insist on qualified professional personnel to supply it. They are also taking steps to improve the quality of their child-care staff through the provision of inservice training courses and the improvement of salaries and working conditions.

But relatively few institutions recognize the need for professional educational personnel to help the children with their school problems. A creative educator, trained in special education and remedial work, can help the children directly by serving as a tutor. He can also provide consultation to the casework and child-care staff as well as to the administrator.

Several educational studies have demonstrated that homework in the elementary grades ordinarily has little value.[4-6] However, this does not necessarily apply to the child who lives in an institution and who, for various reasons, has missed some school experiences and is therefore one or more grades below his age level. A study of children at the Methodist Children's Village in Detroit who attend public school revealed that almost a third of them have had to repeat grades. Many children also cannot read up to the level expected of the grade they are in.

With help from the house mother or tutor, children who are reading 2 or 3 years below grade level can be stimulated to improvement through specific planned techniques. Reading to elementary school children sometimes whets their curiosity for further reading or helps them understand what they have been trying to read. And, vice versa, encouraging the child to read to an adult with whom he identifies and feels secure can build up the child's motivation for school achievement.

We have found in the Methodist Children's Village that beginning with the junior high school level, a regular quiet study period of 45 minutes to an hour can be very conducive to learning, especially if the child-care staff has time to help the children during this period. This means that the staff must not be too encumbered with household chores. Efforts to coordinate the institution's recreational activities with the educational program so that they are not in competition with the study period are also important.

As in so many phases of the institutional program, the child-care worker is a key to the success of efforts to help children with their school achievement. If she is to be helpful in this, she must be sufficiently educated herself and have enough self-confidence to help children with their studies, and to ask advice of the educator when she needs it.

If the child senses a genuine desire to help him do better, he will be encouraged, but he will lose interest if the staff's support and encouragement are allowed to degenerate into nagging. One way of convincing the children of the institutional staff's interest in them is for the staff to participate in community-school functions, such as PTA meetings and father-son nights. Staff discussions with the children's teachers about their progress encourages the teachers to take more interest in the children in spite of the frequent frustrations they encounter.

Equipment

Educational equipment can also be employed by institutions to stimulate and motivate learning. While many institutions recognize the need for adequate recreation and playground equipment, a modern kitchen, and appropriate health facilities, often they overlook the fact that educational toys and games are needed for use in the cottages where the children live. For example, blackboards can help stimulate children of elementary school age to play school. Bulletin boards make it possible for children to display their papers. Toy clocks with movable hands, word games, flashcards, counting games, dice and dominoes are all educationally stimulating as well as alluring to the child who loves games.

Wall maps, globes, and attractively illustrated books, newspapers and magazines—especially children's magazines—as a part of the normal home atmosphere can also stimulate children's intellectual curiosity. Radio and TV sets can provide the children with an opportunity to hear and discuss news programs which can be helpful to them in their social studies.

A set of recent encyclopedias is important for children above the sixth grade and helpful for children in lower grades as well. Sometimes institutions can get community groups to donate such items, particularly at Christmas time.

Institutions can also encourage more interest in nature and biology by providing plots of land for gardening, pictures of birds, small aquariums, and bird cages. Excursions and camping trips can be made more purposeful by more careful planning. Looking over maps, discussing the coming events over the dinner table, and reviewing objects to be observed on the next trip may bring the children an added joy of anticipation as well as broaden the experience for them. Boys scheduled for a trip to the ball park might be drawn into a discussion of batting averages, which might encourage them to figure out their own batting averages when they play their next ball game.

Children need encouragement and stimulation if they are to succeed in school. If these become an integral part of their normal daily living, the chances of resistance to them are lessened and of success increased.

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[1] Gula, Martin: Child-caring institutions. U.S. Department of Health, Education, and Welfare. Children's Bureau. CB Publication No. 368. 1958.

[2] Geake, R. Robert: A comparison of school marks received by institutional children and children living in their own homes. Unpublished research report. University of Michigan, 1960.

[3] Hadley, S. Trevor: School marks—fact or fancy? *Educational Administration and Supervision*, May 1954.

[4] Arnold, D. L.: Spelling lessons and ability to spell. *Elementary School Journal*. September 1941.

[5] Eaton, M. T.: An analysis of factors related to the language arts achievement of sixth-grade pupils. *Research Bulletin of Indiana Department of Institutions*. No. 8. 1944.

[6] Dinapoli, P. J.: Homework in the New York City elementary schools. *Contributions to Education*. Bureau of Publications, No. 719. Teachers College, Columbia University, New York. 1937.

How the use of a pediatric team in a rural area helped health and welfare agencies promote . . .

COORDINATED SERVICES FOR CHILDREN WITH PROBLEMS

AUSTIN W. MATTHIS
Former Health Officer, Imperial County, Calif.

GWENDOLYN BECKMAN
Public Health Social Work Consultant

BELLE D. POOLE, M.D.
Child Health Consultant

California State Department of Health

IN ALMOST EVERY COMMUNITY, rural or urban, some families exist which are worn down by so many problems that they consume a large portion of the time of social and health agencies.[1] While these families have been known to the local agencies over the years, their histories are grim reminders of the tragedy in fragmentation, duplication, and delay in the provision of services and the absence of many types of services needed. This is especially true in the broad fields of health and medical care, for many such families discouraged by a lack of knowledge or understanding seek such care only in crises.

Three years ago a project was established in Imperial County, Calif., designed to solve three types of problems in the way of serving the children of such families more effectively. These problems were: (1) the need for expert diagnoses for children with health and behavior problems; (2) the isolation of agency services; (3) the need for community action to meet gaps in services.

Imperial County is a large rural county, chiefly sustained by agriculture. The county government provides the usual services of a health department, a welfare department, a hospital, schools, and a probation department attached to the court. As is usual in rural communities, these agencies did not at the time of the project have highly trained specialists.

A study of this area, completed just before this project began, showed that one-half of the families received an income of less than $3,000 per year, and over one-half of the unattached persons made less than $1,000 per year. The study also indicated that housing and sanitation were major problems. Nearly one-third of the population were found to live in crowded conditions, one-third of the dwelling units having no inside toilets. One-fourth of the employed population in this area were farm laborers, many of whom follow the crops in California, but consider Imperial County as their home base.[2]

The Beginning

The process of agency cooperation in Imperial County had actually begun before the project was initiated. The health and welfare departments of Imperial County had maintained a close working relationship over several years, and had been coordinating their planning and activities in many fields where their interests overlapped. As a result of this relationship, various child health problems in the county had been identified and ways of eliminating them discussed.

The project itself was stimulated by a specific request. The county welfare department had asked the county health department to help secure physical examinations for children in foster homes.

A great many of the children in foster care were wards of the court, their parents having abandoned them or having been themselves institutionalized.

Both the health and welfare departments realized that many of these children would have problems requiring skilled diagnostic services. For example, a child of 14 months, waiting to be placed in a foster home, was not yet walking. Was the child's difficulty physical or psychological? What was the trouble with the 2-year-old who refused to eat solids and would drink milk only from a nursing bottle? Did the preschool child who had such extremely violent temper tantrums have a neurological problem?

Staff from both departments got together with consultant personnel from the State health and welfare departments to devise a plan. They reached an agreement that the diagnostic services could best be provided by staff from a medical center. The county's small understaffed public hospital, then with no outpatient department, was in no position to provide the service. Consequently, the county turned to a large teaching medical center 225 miles away, the medical school of the University of California at Los Angeles, to provide field service through an interprofessional diagnostic team. This was organized by a pediatrician, chairman of the school's department of pediatrics, who remained the project's coordinator and chairman. Actually an interdepartmental group from the medical school's departments of pediatrics, psychiatry, and preventive medicine, the team also included a pediatric psychiatrist, a psychologist, and a medical social worker. The cost of its services was met by three California State agencies: the State departments of health and of social welfare, and the California Youth Authority.

The Procedures

This team worked closely with two other groups: a local working group consisting of nurses from the health department, social workers from the county welfare department, school personnel, and probation workers; and a group of consultants from the three supporting State agencies.

A clinic session lasting a day and a half was held every 3 or 4 months. The children to be examined were referred by private physicians or by the local agencies—the health department, the welfare department, the schools, the probation department, or the county hospital. Several weeks before the clinic, the social, educational, and health histories of each child and the other members of his family were collected by the appropriate agencies, summarized by the health department, and forwarded to the diagnostic team for review and study. Urinalyses, tuberculin, and hemoglobin tests were performed by the health department on each child selected for clinic appearance before the team's arrival. The team confined itself to the examination of four children, or less, at each clinic session so that it would have time also to interview the foster mothers and, if possible, the child's own parents.

On the day before the clinic session, the psychologist tested each child. The session began with a review of the case materials by the diagnostic team and the local working group together, including information on any developments occurring after the case summaries had been prepared. These discussions brought an important educational byproduct to the local working group, whose questions were answered with care and skill by the visiting experts. For example, a simple yet comprehensive discussion of enuresis which occurred at one session will probably never be forgotten by the local participants.

Following the case review, each child was given a complete physical examination by the pediatrician. The child and his accompanying parent, or foster parent, or both, were interviewed individually by the psychiatrist or the social worker. Occasionally, depending on the age of the child and the nature of the problem, the pediatrician also interviewed the parent. Clinic procedures were adjusted to the needs of the individual case. The psychologist was routinely present during the group sessions, not only for testing but for the discussions.

After the examinations, the team reassembled. with the local working groups and the State consultants to summarize and discuss the findings and to make recommendations for necessary action. Decisions not only had to be made quickly because of the shortness of the diagnostic team's visit but they had to be grounded in the reality of available community resources and skill. Recommendations would be useless that could not be carried out by the local agencies. At the end of the session the social worker or the pediatrician from the team explained the findings to the foster mother or to the child's own mother.

Since its beginning 3 years ago, the project has broadened its focus from children in foster care only to include any child who is presenting problems to the local agencies, to the schools, or to his parents.

The following case of 13-year-old John, whose behavior had been disturbing the community, illustrates what this project means to a child.

John was referred to the clinic by the probation department because of a "strange" body build (long arms, big hands and feet, small head), possible mental retardation, and behavior problems which had resulted in his expulsion from school. Complaints in regard to his behavior included alleged sex activities, laziness, temper tantrums, and lack of cleanliness.

John lived with his mother and two sisters. His father, a seasonal laborer, who had deserted them 3 years earlier, had a record of arrests and jail terms for nonsupport. The family was receiving financial assistance from the welfare department.

The examinations revealed no physical abnormalities, though the boy was physiologically immature for his age, and also showed normal intelligence.

In the ensuing discussion the agency workers seemed disappointed to learn that neither the boy's IQ nor his physical condition provided any explanation of his behavior problems. The discussion, however, established an authoritative foundation for further consideration of the boy's social history and of his family's social and emotional needs. The most striking contributions by the experts were their objective, unwavering focus on known facts, as opposed to hearsay, and their use of the discussion to provide a true learning experience for the participants.

Out of the discussion a plan of action developed, probably quite different from what most of the local workers had expected. This plan included: (1) resumption of school for John; (2) the provision of consultation, in regard to his condition, to the appropriate school personnel; (3) efforts to locate John's father, with the hope of reuniting the family; (4) finding John a recreation project under the leadership of a man with whom he might be able to identify; (5) helping John's mother to understand her son's behavior and also to understand and accept the proposed plan; (6) continued consultation from the diagnostic team to the various local agencies about problems arising in regard to the boy.

Responsibility for providing the consultation to the school personnel was assumed by the health department; for taking steps to find the father and for working with the mother, by the welfare department; for finding the appropriate recreational leader for John, by the probation officers.

Thus the local agencies were helped to take concerted action to guide this boy, who had seemed headed toward an institution, back into the normal stream of life.

Involving the Community

From the beginning, the plans for the Imperial County project included work with community. This was important in view of the hope that the project would one day be completely supported by local funds. Meetings with community leaders and the representatives of various local groups were held on the mornings following the clinic sessions. In addition to the staff members of the involved agencies, those invited to attend included the judge of the juvenile court, the representatives of the Imperial County Board of Supervisors, the superintendent of schools, the school administrators involved in specific cases, teachers, and the district school nurses.

The meetings were conducted on an informal basis in the judge's chamber in the courthouse, and in spite of the fact that they took place on a Saturday morning, there was always full attendance. The teaching team led discussions of problems of local concern and interest in relation to current knowledge of the principles of child growth and behavior and parent-child relationships, but not in terms of any specific child.

Among other subjects to come under discussion in these meetings were: the use of the foster family as a tool in working with children of disorganized, troubled homes; and the usual importance of keeping children of the same family together when foster family placement must be made; the strength of example, on the part of foster parents, in helping adolescent girls establish appropriate behavior toward the opposite sex; the importance of the foster father as an identification figure for the adolescent boy; the strong possibility of future delinquency in an aggressive child from a disturbed home who exhibits behavior problems at school; the place of firmness rather than force in helping the disturbed aggressive child to learn more acceptable behavior.

These meetings often brought to light misconceptions of agency function and sometimes unexpected support for the provision of additional service to fill gaps which became obvious as the discussion ensued. In one meeting the director of the local welfare department referred to his difficulty in establishing a child welfare service. The judge immediately announced that he would have backed efforts to establish such a service if he had known the need existed.

Since then the department has been enabled to employ two child-welfare workers. Other developments in the community which have occurred in the 3 years since the initiation of this project also were accelerated by its effect in highlighting specific community needs. These have included the initiation of an adoption service in the welfare department; the addition to the court of a conciliation service and also a marriage-counseling service; and the establishment of a training project for foster parents, carried out by the State and county welfare departments.

In addition to these developments, a case committee composed of representatives of the same agencies which participated in the diagnostic program meets regularly to develop more effective interagency procedures and plans. The case committee grew out of the discussion of an interagency procedural problem between the school and probation departments, involving a truant adolescent.

The participating agencies are now discussing jointly and within their own staffs ways in which they might work to prevent children from having the kind of problems which bring them to the community's attention. Agency representatives meet with community groups from time to time to discuss the project, and in doing so have created a growing interest in prevention. The type of questions which now come up in the discussion meetings following the clinic are: What factors in the community foster the well-being of its citizens? What are the prevalent attitudes toward minority groups and how do these affect children in growing up? What other community attitudes make it difficult for children?

Reciprocal Advantages

In addition to the advantages provided the children, the stimulus for coordinated services provided the local agencies, and the remarkable opportunity for education provided to the local agency personnel and other members of the community, the project has brought advantages to the sponsoring State agencies and the university medical center which furnished the diagnostic team.

Generally speaking, consultation from State departments to localities tends to be an independent operation because of the structure of the State agencies and the specialized nature of their various responsibilities. This is not due to lack of interest in coordination on the part of the consultants, but to the specific program policies, the departments' patterns of relationship to local areas, and differences in their priorities. In spite of overlapping interests, it is very difficult for large departments to coordinate their consultation services.

Since the initial impetus in establishing this project came from local cooperating departments, coordinated consultation from the three interested State departments became a necessity. Therefore, field consultants assigned to the area by the State departments of health and of social welfare and by the California Youth Authority have attempted to interrelate their consultative activities by discussing their plans together. They have also established a routine of preparing joint field reports relating to their work in Imperial County.

The project provided the diagnostic team from the medical center with an unusual opportunity to observe the health and social problems of a small rural community, the functions and overlapping interests of its various public agencies, and the kinds of resources that are available or lacking to meet the needs of the families and children who are in trouble. This firsthand observation enabled the team members to carry back to their medical students a realistic picture of what practice in a rural community can mean, the kinds of problems which can arise, and the kind of help which can be given even when highly specialized facilities and services are not available locally. It provided them with a wealth of case material pointing to the importance of the team approach to diagnosis, of coordination in the provision of services, and of a coordinated look at the entire family when planning service to a child.

The clinic demonstration lasted for 2½ years. At the end of this time the group from the university medical center recommended that a similar group be established on a permanent basis within the county for carrying out a continuous program. The county board of supervisors accepted the recommendation. As a result the Imperial County Health Department now has on its staff a certified pediatrician as MCH director, and a social worker, as well as a position for a psychologist. The local maternal and child health program has been completely reorganized to provide continuous health supervision and medical care for those families under their care. In addition, it is sponsoring, along with the School of Medicine of the University of California at Los Angeles, a research project in the area of family disorganization, with the hope that this may lead to new methods of service and also bring into focus definite areas of prevention in the field of maternal and child health.

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[1] Bradley Buell and Associates: Community planning for human services. Columbia University Press, New York. 1952.

[2] State of California Department of Public Health: Planning statistics (unpublished).

CASE CONFERENCE

IN LINE WITH ITS GOAL of stimulating interprofessional communication and understanding, CHILDREN with this issue presents its first "case conference," a feature to be repeated with varying cast and story from time to time.

Ever since the establishment of the old "charity organization societies" at the end of the 19th century, "coordination of services" has been a phrase increasingly used by persons engaged in helping people. Still too often the phrase is only a theoretical goal. The following case, taken from actual records, illustrates the tragedy of this. The comments bring the perspectives of a variety of professions to the question of how the situation described might have been avoided and what steps need to be taken from now on.

Readers are invited to contribute to the discussion of this case and its accompanying commentaries through the "Readers' Exchange" section of subsequent issues of this journal.

Whose Responsibility?

Mrs. A was admitted to a State mental hospital in 1958 after having walked out of her house in a small urban community 2 to 3 weeks prior to admission. She left her husband and three young children uncared for. Her husband, a plumber, had to make some arrangements for the care of the children, so he asked his 65-year-old grandmother to care for them in his home. He said, "She did pretty well but she's kind of old and it was hard for her to care for such young children." He was working long hours, often from 7 a.m. to late at night if emergency plumbing installation was necessary. Unless he did the extra time he would be fired. Later he reported, "Because I had to get to the hospital to see my wife and help my grandmother with the children, I kept asking my boss for time off and was soon fired. Then I just stayed at home to care for the children until my wife came back from the hospital 6 weeks later. I was able then to do some outside painting until the cold weather came. Since then I have been receiving unemployment compensation, but it will soon be used up."

Six months after Mrs. A's discharge from the hospital, a visit was made to her home by a research social worker making a study of the care of children whose mothers are hospitalized. The research social worker had already seen Mrs. A once in a hospital. Mrs. A was found sitting at the kitchen table crocheting. She was obviously pregnant, a fact that had not been noted in her hospital record nor mentioned in the prior interview with the research worker. Sitting with her was Tom, her 2½-year-old son, whose face was dirty and whose nose was running profusely. Mrs. A started by saying, "Things have really been tough since I last saw you, particularly because my husband can't find a job anywhere, although he goes out practically every day looking for one." She explained that he had just left to look for a job in a local store since he had a lead that there might be one. In a few moments he returned saying there was no job available.

Mr. A explained that he had been "all over the place looking for a job and to nearby States, but I can't find any work. I'm getting worried because my unemployment compensation of $37 a week runs out in a few weeks. And now we have more trouble because my wife is 7 months' pregnant, and she hasn't even seen a doctor yet. Last week I tried to get a doctor because she was having some bleeding. I called six doctors and explained that I was out of work for several weeks so I didn't know how I could pay the bill, but my wife was 7 months' pregnant, was having some difficulty, and needed a doctor. Three doctors said they weren't taking maternity cases any longer; one said he was too busy; and the other two said they could not accept a maternity case at such a late date. For the last baby we went to the clinic in the hospital, but now they have a rule that you can't get into the clinic or hospital without your own doctor, so I don't know what we're going to do. Perhaps I'll call a few more doctors, but I won't explain that my wife is so far along or that I am unemployed; maybe that way we can get someone to see her."

In reference to the question by the research social worker as to the family's use of the social, health, or welfare agencies that exist in this community, Mrs. A replied, "Three years ago when I tried to commit suicide I saw a social worker in a child and family agency, and I saw her two or three times after my last baby was born. But I really never cared for her because she insisted that my husband owned a business and would not believe that he didn't. My husband later went to that agency when I was in the hospital and tried to get a babysitter, but that didn't work out either. So I guess we've got to get along on our own somehow. These doctors and agencies don't seem to be available when you need them the most."

Commentary

A PUBLIC HEALTH NURSE

All of the professional workers who read this case must be distressed by the failure of every social agency to help the family. One would like to believe that it could not happen in one's own community. However, it is only too possible many places. Gaps in services, multiplicity of agencies, and lack of adequate staff make it ever more urgent to institute a system of interagency and interdisciplinary communication and make it work.

There were several obvious crises in the brief history given here when the representatives of the agencies which knew the family might well have thought of the need for continuing health supervision: the attempted suicide; the admission to the mental hospital; and the four pregnancies. Other people less directly concerned also knew something of this family's problems—the former employer, the six physicians who were called, the hospital clinic personnel, and the research social worker himself, who had interviewed the wife in the hospital. Though a public health nurse is not mentioned, it is probable that there had been opportunities for such a nurse to know this family, perhaps in a prenatal clinic or a well-child conference.

The total absence of a public health nurse is a glaring failure in this case. In most places, she is the common denominator among the health disciplines—the person nearest to the family and therefore a strong link in the chain of communication. She can share information with other agencies and give such nursing care and health guidance as are appropriate. Perhaps more important, she can be a helping person close to the family. In her "big sister" role [1] she may make a valuable contribution to the family's mental health. Because there are more public health nurses than other types of professional people (though not enough), and they often have a readier entree to homes, they provide a good channel for community health services and a practical means of supplementing skills in more limited supply. Even without an organized referral plan, the nurse's long-term contact with families makes it possible for her to direct them to the existing resources and bring their needs to the attention of others at times of stress.

It is evident, however, that the medical and social agencies which have been concerned with this family have not been able to provide the immediate followup and care indicated. Perhaps this means that everyone's responsibility is no one's.

Such acute situations as this will be repeated until health and social agencies make a plan for working together. A council of social agencies may be the nucleus for such a plan. But a wider referral system is needed, since patients are often admitted to institutions outside the local jurisdiction. In the case described, for example, a referral from the State mental hospital might have moved the family service agency to give assistance in arranging for day care or homemaker service which would have enabled the father to keep his job. If this was not possible, visits by a public health nurse might have given the grandmother enough help to care for the children at home.

The director of the local health department is one of the officials in a strategic position to start joint planning, or to give leadership in the reorganization of a plan that has broken down. This official agency does have a responsibility for community planning to meet the health needs of the population. It should be recognized that a referral system is only a first step. This should lead to an arrangement for conferring and problem solving.

In the present emergency, the research social worker will no doubt recognize the need for immediate obstetric care and report this to the local health department. Thus available sources of medical and hospital care can be brought to the patient. From this point, a new beginning can be made in learning the family's needs and finding a way to meet them.

KATHARINE AKIN
Associate Director, Public Health Nursing Service, Georgia Department of Public Health

A MEDICAL EDUCATOR

When Mr. A inquired at the local agency about a "babysitter," the chain reaction terminating in the degeneration of the economy and morale of this family would have been avoided if a referral could have been made to an efficient homemaker service. Failure to mobilize this assistance could stem from either lack of a homemaker service in the community or lack of information on the part of the agency worker that such did exist. An up-to-date directory of available services is indispensable to good medical or social practice and should be consulted as readily as the telephone directory until the professional person involved develops a working knowledge of where to get the help which is indicated.

Mrs. A suffers from two medical problems: arrested emotional illness and present complications of pregnancy.

Whose responsibility to see that her problems receive attention? Before she was discharged from the mental hospital, the physician in charge of Mrs. A's care was responsible for knowing about the home situation to which she would return, and for referring her, through a paramedical assistant, to a local psychiatrist, mental health clinic, or "home care" program.

Whose responsibility? The research social worker could also have obtained the facts about the home situation and have triggered action in the home community to ameliorate the complicated family situation long in advance of Mrs. A's discharge from the mental hospital. A local agency (physician, mental health clinic, or family agency) should have been alerted to get an appropriate person into the home to care for the children so that Mr. A could stay on his job, and to prepare the home for Mrs. A's return so that she would find a situation which would aid rather than exacerbate her emotional illness. (From the timing of events, it is doubtful if the mental hospital medical personnel could have detected Mrs. A's pregnancy prior to her discharge.) Admission of Mrs. A to the local maternity clinic could then have been facilitated by the local physician or agency to whom Mrs. A should have been referred by the research social worker or by the responsible physician in the mental hospital.

The neglect and deterioration of the A family is a consequence of a breakdown in communication bebetween professional people at every step in this long sad chain of events. Good medical and related social work practice is impossible if professional people do not share information and cooperatively set a course of action suited to the needs and requirements of the patient and family. That the family must act responsibly is also essential. Failure of such collaborative action leads to human wreckage of untold cost to the health and well-being of the patients, the family and the community.

What can and should now be done after all the damage has been created? A conference of very busy and overburdened professional people will have to be held in the local community to review the facts, organize resources of people, time, and money to develop and act in concert with Mr. and Mrs. A on an appropriate plan. This would require, at a minimum, three or four conference-hours of an obstetrician, a psychiatrist, a psychiatric social worker, a psychologist, a public health nurse, or visiting nurse from a voluntary organization, a worker from the local welfare department, and a worker from a local family agency. And then the plans made in these conferences must be carried out and followed up. An expensive course of action? Most certainly. But it is cheap compared with the long-term cost to all concerned in time, money, and suffering if the A family is allowed to drift further into deeper and deeper dependency.

J. GARTH JOHNSON, Ph. D.
Professor and chairman, Department of Community Health, Albany Medical College of Union University, Albany, N.Y.

A PUBLIC HEALTH PEDIATRICIAN

There are several medical problems which this case presents: maternity care for the mother; psychiatric care in view of the probability of recurrence of the mental disorder; and medical care and health supervision for the 2½-year-old child. In addition, planning needs to be undertaken promptly for care of the child and maintenance of the integrity of the household in the event of a recurrence of the mother's mental disorder. The father needs help to secure employment, and steps should be taken to assure family income maintenance.

An integrated, regionally or locally administered health and welfare service, bringing medical, social, and psychiatric resources into action would be the most effective means of dealing with situations of this type. In the absence of such a service, a family service agency could well assume central responsibility, if one exists in the area. If not, the necessary minimum would be a joint consultation of the psychiatric hospital staff, the local welfare department, the local hospital, and local health department, with assignment and acceptance of responsibilities by each.

The mother's mental disorder in this case has existed for some years and was known both to a social agency and doubtless to a general or psychiatric hospital at least 3 years previously, when suicide was attempted. Services should have been begun then and continued. It appears that the social agency allowed the family to drop from sight and that no psychiatric care was provided following the attempted suicide—oversights difficult to justify in the light of the likelihood of further problems.

The case illustrates the need for both the social worker and physician who initially recognize the existence of a problem such as this to determine upon a definitive plan of action and to pursue the plan (revised as necessary) for an extended period of time.

WILLIAM M. SCHMIDT, M.D.
Head of the Department of Maternal and Child Health, Harvard School of Public Health

A PUBLIC WELFARE WORKER

As has been stated so clearly in "Multi-Problem Families—a New Name or a New Problem":[2] "It has become increasingly possible for families to 'fall through' the network of agency services with no single agency taking specific responsibility for 'seeing the family through' over a period of time." The point is well illustrated in this case. The A family needed the guidance and support of an agency which could provide, through its own programs or by referral to other agencies, the various services indicated—homemaker service, financial assistance, psychiatric treatment, medical care, employment counseling, and so on.

In the public welfare agencies we have long since learned that referrals need followup and that there must be "ready means for interagency collaboration on individual families."[2] But first, there must be agreement on which agency will follow through and retain responsibility for securing services as they are needed. We believe that the public welfare agency because of its basic and broad responsibilities will increasingly be the focal point in most communities to provide the needed social services and to arrange for essential services in other fields.

There is another aspect, too. Does the community provide the variety of services families may need? Too often community patterns do not change to meet new needs or to provide new tools.

The cost of providing needed services is sometimes another block. Whether tax funds or voluntary contributions or both are involved, it is often difficult to interpret need with sufficient authority to secure financial support locally. Demonstration projects continue to be one of the best methods of interpretation, and funds for these are now more available than they used to be, from both private sources, such as foundations, and public sources, such as increased child welfare services funds from the Children's Bureau. Funds are also available from the National Institute of Mental Health, Public Health Service.

To give an example of the value of demonstration programs: The North Carolina State Board of Public Welfare in 1947 used a small portion of its grant of Federal funds from the Children's Bureau to demonstrate the effectiveness of homemaker service for children. Ten years later funds from the Doris Duke Foundation were used to demonstrate the value of such a service in helping aged and disabled persons remain in their own homes. The demonstrations pointed up the values dramatically enough that "across the board" homemaker services are now being developed as ongoing programs in county departments of public welfare.

One last word, this about staff, at the risk of belaboring a point with which we are all too familiar. We must have in every corner of this country more and better trained staff if we are to see fewer families fall through the network of agency services. On the other hand, we will never have all the staff we need so let us not wait for that to happen before we move. Imagination, enthusiasm, and determination go a long way too.

MYRTLE WOLFF
Director, Division of Child Welfare, North Carolina State Board of Public Welfare

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[1] Caplan, Gerald: The mental hygiene role of the nurse in maternal and child care. Reprinted in *Concepts of mental health and consultation*. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 373. 1959.

[2] Social Research Services, State Charities Aid Association: Multi-problem families—a new name or a new problem. New York. 1960.

An essay review . . .

THE ORIGINS OF DELINQUENCY

CATHARINE V. RICHARDS
Youth Services Consultant, Welfare Council of Metropolitan Chicago

IN a recently published book, "Delinquency and Opportunity, a Theory of Delinquent Gangs,"[1] Richard A. Cloward and Lloyd E. Ohlin explore two basic questions baffling most observers of delinquent gangs:

1. Why do delinquent "norms" or rules of conduct develop?

2. What are the conditions which account for the distinctive elements of specific systems of delinquent norms?

In pursuing these questions they reach the conclusion that delinquency is, in the main, the product of the interaction of social systems—and that therefore social systems and their values are the most logical targets for preventive efforts.

Rigorously adhering to an analysis of precise propositions, stemming from the theoretical formulations of Durkheim[2] and Merton,[3] the authors take the reader through a critical examination of various theories of delinquency. By concisely limiting their definitions to fit their purpose, they develop a dynamic theory of delinquent gangs that can account for changes in the structure and behavior of gangs over a period of time.

The writers abstract from the omnibus of delinquency a manageable unit of deviant behavior and designate this as a "delinquent subculture." This subculture they define as ". . . one in which certain forms of delinquent activity are essential requirements for the performance of dominant roles supported by the subculture."

They then identify three subcultural differentiations that are prevalent among adolescent males in some lower class areas of urban communities. These subcultures constitute routes of adjustment to the environment and its prevalent values from which the adolescent gangs take their specific colorations. These are of three types descriptively labeled according to the central position or dominance accorded the delinquent activity: (1) *the criminal gang* in which the group goal is material gain through illegal means such as extortion, fraud, or theft; (2) *the conflict gang* in which violence is the focal interest and status is achieved through physical force or intimidation; (3) *the retreatist gang*, characterized by its dominant interest in the use of drugs.

The distinctive elements of these gangs evolve according to the interaction of the social structures of the community, specifically between those relatively stable systems which accommodate different age levels of people and bring together the carriers of conventional and of deviant values. For example, in some parts of Chicago the youth may see and describe a criminal model as the man with "clout (influence), women, and Cadillacs" who is not on the "slave" (indicating he doesn't earn his living by legitimate work). At an early age in such an area, the youth may begin to steal for a variety of reasons that are mostly sanctioned by the people in his neighborhood. Gradually his stealing brings him into contact with fences, bondsmen, law enforcement officials, politicians, fixers, and so on. Here are the intermediaries between the conventional values of the larger society and the deviant values of the subculture. There develops an interdependency between the subculture and these intermediaries in which each serves the other. This creates an environment nurturing delinquency.

The authors suggest that youth living in such environments are confronted with a major problem of adjustment because of the disparity between "what they are led to want and what is available to them." Where the youth have internalized conventional goals, where they have limited avenues to these goals and are unable to revise their aspirations downward, "they experience intense frustration." To manage the frustration, the youth may explore the adaptive routes of criminal, conflict, or retreatist structures.

This theory of delinquency and opportunity is logically trim and neat. The writers deliberately exclude considerations that introduce complexity. For example, in Chicago the heaviest incidence of delinquency in a given area is 21 out of 100 male youth 12 to 16 years of age.[4] The question the theorists acknowledge but do not encompass is: Why is it only a small proportion of the population exposed to a relatively similar environment handle their frustrations by resorting to an "exploration of nonconformist alternatives"? The theory builders extricate themselves from this difficulty by making it vividly clear that they are focusing on delinquent norms rather than on delinquent acts.

Regardless of this shortcoming the book is singularly significant from the viewpoint of both theory and practice. The writers see delinquency as a product of the interaction of social systems. They conclude that the target for preventive action is not the individual or the group with the delinquent pattern, but the "social setting that gives rise to delinquency." It seems to follow that this may constitute an invitation to social change. Those who want to take action against delinquency will have to systematically study and bring about change in the principal structures of the community; namely, government, education, business and industry, recreation, family, and religion. Intervening strategically with the operation of systems, that are in themselves systems, in order to create a nurturing environment for human potentials is a complicated and difficult task requiring concerted and comprehensive action of many forces in the community. To the extent that this is achieved, children and youth will be provided with a social milieu favorable to their growth in a democratic society.

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[1] Cloward, Richard A.; Ohlin, Lloyd E.: Delinquency and opportunity, a theory of delinquent gangs. Free Press, Glencoe, Ill. 1960. $4. 220 pp.

[2] Durkheim, Emile: Suicide; a study of sociology. (Translated by J. A. Spaulding and George Simpson; edited by George Simpson.) Free Press, Glencoe, Ill., 1951.

[3] Merton, R. K.: Social theory and social structure. (Revised edition.) Free Press, Glencoe, Ill., 1957.

[4] McKay, Henry D.: Rates of delinquency in communities in Chicago 1953–57. Institute for Juvenile Research, Chicago, June 1959. (Mimeographed.)

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

MAN ENOUGH FOR THE JOB. 25 minutes; sound; color; purchase or loan.

Tells the story of how membership in a 4-H Club helps a city boy adjust to country life by instilling in him a sense of personal pride and responsibility.

Audience: Group workers interested in activities of young people between the ages of 10 and 21.

Produced by: Sam Orleans & Associates.

Distributed by: Sam Orleans & Associates, 211 West Cumberland Avenue, Knoxville 15, Tenn.

YEAR OF BIRTH. 27 minutes; sound; black and white; loan.

Describes a study of the conditions leading to brain damage in infants. The study is being made by the National Institute of Neurological Diseases and Blindness in collaboration with universities.

Audience: Students in fields concerned with maternity and infancy; general public.

Produced by: Norwood Studios.

Distributed by: Mrs. Ruth Dudley, Information Officer, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda, Md.

MOTHER LOVE. 26 minutes; sound; black and white; rent or purchase.

Shows experiments with rhesus monkeys indicating that body contact is the single most important factor governing an infant's love for his mother, and that deep emotional disturbances, even death, can result from deprivation of such contact.

Audience: Profressional persons concerned with child development.

Produced by: CBS Television, New York.

Distributed by: Carousel Films, 1501 Broadway, New York 36, N.Y.

PLANNING CREATIVE PLAY EQUIPMENT FOR YOUNG CHILDREN—Part 1: Outdoor. 10 minutes; sound; color; purchase.

Shows how parents in a community combined their talents and imagination to build a playground for 60 preschool children, making use of waste materials, planning centers of activities, and constructing safe and sturdy play equipment.

Audience: Community groups, parent associations, teachers, city planners, boards of settlement houses, and other agencies planning for young children.

Produced and distributed by: University of California, 405 Hillgard Avenue, Los Angeles 24, Calif.

BOOK NOTES

DELINQUENT AND NEUROTIC CHILDREN; a comparative study with 100 case histories. Ivy Bennett. Basic Books, New York. 1961. 532 pp. $10.

Probing the backgrounds of 100 boys and girls under treatment at child guidance clinics, the author found in the 3-year study she reports here, support for the theory that different patterns of personality structure and interrelations exist in families of delinquents and in those of "passive neurotics." Also confirmed, in her opinion, was the theory that primary influences shaping a child's development and behavior are to be sought in the very early years.

The book presents individual psychological profiles of the children, who ranged in age from 5 through 16 years.

Supplementing the histories are results of intelligence tests, extracts from treatment session reports, and followup reports on therapy. An appendix with 47 tables includes data on clusters of factors affecting delinquent children and the neurotic group, and their respective interests and achievements.

The author, who includes copious references to the literature on delinquency and neurosis of children, urges team collaboration combining "the outlook of dynamic psychology with the technical methods of modern research work."

BLIND CHILDREN in family and community. Marietta B. Spencer. Photographs by Frank Agar, Jr., and Carol Safer. University of Minnesota Press, Minneapolis. 1960. 142 pp. $4.25.

The ways in which child guidance principles can be used to start blind children on the road to healthy, useful, and meaningful lives are suggested chiefly through captioned photographs and through occasional textual commentary.

For the benefit of families and professional workers concerned with the training and welfare of the blind, the author, a medical-social worker, has selected views showing blind children of preschool ages in action—eating, playing, going to bed, dressing, and learning simple habits and skills. Her central theme is that these children have the same needs, problems, and potentialities as children who can see. Much depends, she maintains, on community attitudes towards the blind child's family and on how much these attitudes meet the family's social and emotional needs.

Publication of the book was financed by the Hamm Foundation and the American Foundation for the Blind.

ESSENTIALS OF FAMILY LIVING. Ruth M. Hoeflin. John Wiley & Sons, New York. 1960. 282 pp. $5.75

This book was written as a text for college students interested in preparing themselves for adult responsibility of family life. Through the discussion of growth and developmental ages and stages, an attempt is made to help the student to achieve a better understanding of self as a step toward achieving emotional maturity.

The developmental approach is used to interpret family composition, the family cycle and the interaction processes within the family. The book discusses the adult-centered versus the child-centered home, especially in relation to the impact of the advent of children into the family unit. Throughout the book, the theme of providing a feeling of love and security is interwoven with the child's need to operate within fairly well-defined limits.

The book provides case stories and other illustrative material and lists discussion questions and references at the close of each chapter.

While the book is directed to college class use, it could be used as resource material for public health nurses and others working with adolescents and their families.

JORDI. Theodore Isaac Rubin, M.D. The Macmillan Co., New York. 1960. 73 pp. $2.95.

The gaping hole of the garbage can, like an ear that can hear his thoughts, and the stubby, raining trees that come down to look for him and strangle him with their roots are part of the inner world of Jordi, the schizophrenic child in this story.

Written by a psychiatrist affiliated with the American Institute for Psychoanalysis and the Karen Horney Clinic, the tale follows the 8-year-old hero's escape and exploits in a New York subway, his voluntary return, and his steps to recovery in a special school. Like a theme in counterpoint, the parents' reactions and activities as well as test results are brought in periodically.

ANXIETY IN ELEMENTARY SCHOOL CHILDREN. Seymour B. Sarason, Kenneth S. Davidson, Frederick F. Lighthall, Richard R. Waite, and Britton K. Ruebush. John Wiley & Sons, New York. 1960. 351 pp. $7.75.

Focusing on anxiety about tests and test-like situations as a major cause of the gap between performance and potential of the elementary school child, the authors present results of 6 years of research, supported by the National Institute of Mental Health, Public Health Service, on anxiety among school children in three Connecticut communities. All of the authors are associated with Yale University. Stressing the test-giving and test-conscious character of our culture, they suggest that clarifying the test factor in anxiety will illuminate knowledge of anxiety in general.

The authors see relationships between anxiety over tests and attitudes about self, unconscious significances, parent-child relationships, and other anxieties, and regard test anxiety as a danger signal.

Using test-anxiety and general anxiety scales in studying the children, they found that the child who is highly anxious about tests is more sensitive than other children to the way adults seem to regard him—for instance it makes a difference to him in what order the teacher calls upon him. They also found that test-anxious children had been exposed to more unfavorable experiences than the other group, and their distribution showed little relation of such anxiety to class.

Interviews with parents showed that fathers were more aware of the children's degree of anxiety than the mothers, particularly those mothers of highly anxious children.

HERE AND THERE

International Conference of Social Work

The 10th International Conference of Social Work, held in Rome, Italy, January 8-14, 1961, was larger than any of its predecessors. The registration was over 2,400 with 51 countries represented, although only 28 countries have national committees representing the conference.

Theme of the conference was: "Social Work in a Changing World: Its Functions and Responsibilities." As with the previous conferences, the program was organized with plenary sessions in the morning and with meetings of the 6 commissions and 16 study groups in the afternoon. Because of the large attendance, special afternoon meetings were held for those who could not be accommodated in the commissions or study groups.

At the first plenary session, the chairman of the Italian committee set the tone of the conference. Pointing to the fundamental tenets of social work—the importance of human dignity and the rights of the individual—he said that social workers must help lead man to knowledge of his own dignity and the dignity of community life. Opening up new vistas for social work, he added: "We can no longer speak of old worlds and new worlds. All countries are evidencing marvelous energies of renewal."

George Davidson of Canada, the president of the conference, threw out direct challenges to complacency by asking the conferees the question: "Is social work changing with the changing times?"

One sensed early that the concerns and emphasis expressed in this conference differed from those of previous conferences. Gone was the concentration on problems of mass poverty and want, and on the methods of dealing with these problems. And, significantly, the cold war did not raise its ugly head. Instead, there was the constant reminder that we are living in an ever-changing world, the needs of which are constantly evolving, and that social work must gear itself to these changes in order to make its unique contribution.

This theme of "change" was reiterated throughout the conference. It was pointed out that while change is rapidly taking place in every country, the pace of change varies from country to country. We were told that where change is most rapid, most can be learned; that therefore social workers have much to learn from the so-called "developing countries." Thus, change was viewed as something to be welcomed.

But while change was viewed as a stimulating challenge, many concerns were expressed in relation to it. Much was said about the problems which come with industrialization and urbanization. It was pointed out that as an increasing part of the population of a country concentrates in large towns, deep social and cultural changes occur. Man is deprived of cultural values and finds nothing to take their place. He relies less and less on his family. The family no longer assumes the responsibility it once had for both the physical and emotional support of its members. While social security helps to give man a sense of security, it tends to make him feel "like only a number."

Industrialization brings a higher standard of living, but it may bring a greater gamble to families and individuals, one speaker said. The destitution that some people experience as a result of industrialization tends to be greater than that experienced by people who live on the land. Man becomes increasingly alone in his environment as the cohesiveness of his family group weakens. New kinds of skills and adjustments are required of him.

It was also pointed out that in countries that are industrializing amid political upheaval, social workers are trying to accomplish in a decade that which has taken place over long periods of time in other countries. But there was a strong consensus that social work must give more recognition to the problems individuals have to face in a highly industrialized society.

Great concern was expressed in relation to the huge new forces which have been released by man in recent decades. This posed the unanswered question: Will these forces be used for the welfare of man, or will they be used for the destruction of man himself?

Social Work's Importance

Recognition of the importance of social work in the world today focused attention on the broadening scope of social work, a scope expected to continue to expand in the years ahead. Social work was described as a dynamic activity, shaped by the social, economic, and cultural conditions of the various countries in which it is carried out. These dynamic aspects and the effects of change were seen as reflected everywhere.

In the postwar period, social work had to face problems of reconstruction, of saving and reshaping lives. It had to start with the stern necessity of feeding the hungry, reuniting families, resettling the displaced. This was a time when social work policy grew out of negative attitudes and a variety of fears. Now, at Rome, social workers from everywhere showed that they felt this to be no longer necessary, that now is the time to work for a constructive world.

One speaker advocated more active participation of the users of social work in the social work process, saying that this will prevent the dehumanization of social work. We can only have successful community development, he said, if the users are aware of their needs and can take part in the efforts to meet them. Recognizing that this demands the preparation of the users, he pointed out that this preparation was an important task for social workers.

The conferees showed grave alertness to the fact that today's evolving society is bringing increasing problems of relationships "between man and the world and between man and other men" because, as one speaker put it, "existence in the world is now one of coexistence." They saw social work as having an important role in establishing significant relationships between man and his institutions. They stressed the need for teamwork and coordination of services. In the past, one-dimensional approaches were the order of the day. Today's challenge, as expressed at Rome, is to fit each of these dimensions into social work's wider role.

Definitions

Dr. J. F. de Jongh, director of the *Amsterdamse Sociale Academie*, in differentiating between "social welfare activities" and "social work," used the term "social welfare activities" to cover the broad range of efforts directed toward improving the quality of social life. He reserved the term "social work" for specific activities requiring certain kinds of competence. Social welfare, he said, represents the activities of many people to improve the welfare of individuals and communities. It takes different forms: services to individuals; social action; and community planning. It involves values, philosophy, and social resources.

Social work, he asserted, is emerging gradually from the social welfare field. It calls for special competence to diagnose and understand human activity and problems and how to deal with them. He traced its beginnings to the time when social welfare workers began to see phenomena around specific problems—alcoholism, juvenile delinquency, family breakdown—and began to develop skills in dealing with individual cases of such problems in a more scientific way. This type of work, he maintained, is still the core of social work; although social work has moved on to achieve a greater understanding of the surroundings of clients, which has led to an interest in community planning.

Dr. de Jongh further distinguished the two fields by stating that social work is an activity carried out by trained specialists, while social welfare is a citizen's concern. In the social welfare field, leadership should belong to the community as well as the choice and direction of activities, he maintained. Volunteers are the community's agents, he pointed out. Social work, on the other hand, since it requires a special competence, must be an activity of trained professionals, he insisted.

Social workers have a function in the social welfare field, said Dr. de Jongh, but a limited one, leaving plenty of room for others, especially other helping professions many of which are reaching out into this new field of human adjustment and human relations.

At the close of the conference one had the feeling that social work has achieved a significant and growing place of importance in our society today, and will be needed more and more in the future. We were told that the world must be committed to the defense of human values and while the history of mankind has been a chain of tears and miseries, it has also been one of hope and aspirations. As Nathan Cohen, dean of the School of Applied Social Sciences, Western Reserve University, said at the conference, "Social work has the conviction that man can be the master of his fate and, with his collective strength, can build a better world."

Mildred M. Arnold

Youth Fitness

The key to promoting physical vigor among the Nation's youth rests with the individual family rather than with the Government, said President Kennedy, addressing the Conference on Physical Fitness of Youth, held in Washington, D.C., on February 21, 1961. Summoned by the President to help chart guidelines for official action toward fitness goals, the 165 conferees represented chiefly physical education, sports, health, and youth groups, and appropriate Federal agencies. They were also addressed by Attorney General Robert F. Kennedy and Secretary of Health, Education, and Welfare Abraham A. Ribicoff, who emphasized the need, in the exacting years ahead, for "people who can work hard and think fast."

Six work group discussions stressed the role of good health in the full use of intellectual powers. The participants underscored the need for substantially revising health and fitness related activities of school systems and community agencies, and urged communities to organize demonstration programs testing new ways of meeting the health and recreational needs of youth.

Among conference recommendations for Federal action were:

- Expanding the National Defense Education Act to support further development of high-quality programs of school health, physical education, and recreation.
- Promoting the use of school facilities for after-school and weekend play.
- Seeking ways to foster among children those leisure activities with high carryover value.
- Stressing physical education programs in the Nation's elementary schools.
- Setting up a task force to review the relationship of the President's Council on Youth Fitness with the activities of 34 Federal agencies serving youth and children.
- Expanding the Council's staff and setting up field representation in each of the nine regions of the Department of Health, Education, and Welfare.

For Youth

On March 1, 1961, President Kennedy signed an executive order creating the Peace Corps, an agency that will send out volunteers to build, teach, and work in newly developing countries. Financed by the President's contingency funds, the activities of these "doers and workers" are planned to dovetail with the advisory and consulting functions of other official missions abroad. Fields of action for the volunteers, as mapped out in the basic "working hypotheses" prepared by R. Sargent Shriver, the Corps Director, include education, health, agriculture, and large-scale construction and industrial projects. Assistance in the form of money and manpower may be channeled to private projects, if certain criteria are met.

Plans call for national recruiting of persons over 18 years of age who possess technical ability needed in specific projects, physical stamina, and emotional stability.

Initial sifting is accomplished through a four-page questionnaire, which was distributed for the first time in late March by a skeleton force of the 75 staff members recruited up till then. The first recipients were the 20,000 persons from whom inquiries have been received—the majority of them college students, but also including physicians and other professional people. Batches of questionnaires also went to 2,000 colleges and Agricultural Extension Services, and some 4,000 post offices. The questionnaire consists of short-answer questions on type and degree of technical skills, education, work and hobby experience, language ability, and knowledge of selected foreign cultures.

Applicants will be tentatively chosen after interviews and further examinations held at 54 places throughout the Nation and outlying regions, and then trained for 3 to 6 months. The usual length of service will be 2 years, during which the volunteers will be paid subsistence allowances only; payment of $75 per month of service will be made on completion of their terms. Service in the Corps will defer but not exempt the volunteer from service in the Armed Forces. During both service and training, Corps members are subject to separation if they cannot meet the new challenges.

The Corps plans to have several hundred volunteers in the field by the end of 1961.

* * *

Under discussion at the Interdepartmental Committee on Children and Youth, is a proposed nationwide work and service program for youth presented to the committee at its December 1960 meeting by its Subcommittee on Transition from School to Work. The Interdepartmental Committee is a coordinating body of 34 Federal agencies serving children.

The program would have the following features:

- The Federal Government, States, and local communities, with Federal financing, would employ youths of 16 to 21 years of age full time on projects sponsored by voluntary nonprofit groups and public agencies.
- The projects would involve service in hospitals, day-care centers for children, museums, parks and forests, programs for the aging, libraries, citizenship and literacy programs—operating at the community, county, State, or Federal levels, or internationally through voluntary agencies, the State Department, or the United Nations.
- Initial distribution of funds would follow a formula based on the ratio of the population between 16 and 21 in the State and local community to the nationwide population in this age group. Ten percent of the funds available would be withheld at the Federal level for national and international projects.
- Participation would be voluntary with universal eligibility for all within the age group, except that those under 18 would be required to have the consent of their parents or guardian. It would be open to 100,000 young people the first year, 200,000 the second, and 300,000 the third and thereafter.

* * *

Projects for the Retarded

Forty-nine States and 3 other U.S. jurisdictions are now emphasizing special programs or related activities concerned with mental retardation as part of their maternal and child health programs.

None of these programs existed before 1954, the year the Children's Bureau first granted funds through its health services programs for the development of four demonstration diagnostic clinics—in California, Hawaii, Washington, and the District of Columbia. The inclusion of $1 million of funds earmarked for services to the mentally retarded in the congressional appropriation to the Bureau in 1957 and in subsequent years has resulted in the rapid multiplication of these maternal and child health projects. Many of the States have been adding their own funds to expand the projects and make them a regular part of the State programs.

As the score now stands in the maternal and child health programs:

- 52 States and jurisdictions have planned some special service for mentally retarded children.
- 46 States are offering clinical services to retarded children.
- 14 medical schools are using the clinical services to train medical students, residents, and interns.
- 50 of the Nation's 82 special clinics for retarded children have been developed through this program.
- 10,000 retarded children mostly under age 9 and their parents are annually served by these projects.
- 26 States have developed programs for the detection and treatment of phenylketonuria.
- 25 infants with phenylketonuria have been located and placed under treatment (and mental retardation prevented) in 1960.

Many of these programs include study aspects, such as the dental problems of the retarded, retardation among Indian children, and the needs of children on waiting lists of State institutions.

The Youth Studies Center, University of Southern California, is using Santa Monica as a demonstration community for three types of studies involving the participation of lay and professional leaders, personnel serving youth, and hundreds of adolescents. The studies include a social profile of the community, with an accent on the youth; the critical factors in transition from youth to maturity, in longitudinal perspective; and authority relationships of the individual adolescent.

Children of Migrants

Over 500,000 domestic agricultural migrants and their families—including between 350,000 to 450,000 children under 18—are "trapped in a vicious circle of unending poverty and rootlessness," according to a report prepared by the Children's Bureau. This report was prepared at the request of the Senate Appropriations Committee of the 86th Congress and submitted by the Secretary of Health, Education, and Welfare in January 1961. Facts are presented on the families in the country's five major agricultural migrant streams, gathered from a wide spectrum of sources, ranging from Federal, State, local, and voluntary agencies to congressional and executive committees. Among its highlights are:

- Migrant farm workers represent the lowest economic level of any major group in this country, with average earnings of $859 annually; and, along with their children, the lowest educational attainment.
- In the entire Nation there are 24 State-licensed day-care centers primarily servicing domestic migrant children, with a combined capacity of fewer than 1,000 children. Thirteen of these centers are in one State, New York.
- About 42 percent of the 813 counties in the United States affected by family migration have no full-time, public child-welfare services. Of 39 counties estimated to have 5,000 or more migrant workers, 10 have no available service from a full-time, public child-welfare worker.
- Migrant families have higher infant and maternal mortality rates, and

more diarrheal diseases, nutritional deficiency, and communicable diseases than the rest of the population. A large proportion of pregnant women in migrant families receive no prenatal care.

- The migrants' access to existing health and welfare services is hindered by cultural differences, language barriers, lack of education, mobility or nonresident status, long distances to clinics, and shortages of health and welfare workers.

The report reviews the origin of agricultural migration in this country, the composition of the migrant population, and the history of Federal, State, and voluntary efforts to better the conditions of these workers.

In conclusion, the Children's Bureau recommends the following steps for immediate action:

- Expanding child-welfare and maternal and child health services for migrant families, by increasing current services and developing and demonstrating new adaptations, especially of day-care, well-baby, and other outpatient services.
- Providing more advisory assistance and guide material to agencies and organizations helping migrant children.
- Giving more encouragement and assistance to research and demonstration efforts toward developing new or improved measures for aiding these children, in the fields of child welfare and health.
- Increasing, investigating, reporting activities related to the development of effective measures for improving the health and welfare of migrant children.
- Informing the public of findings derived from these activities through a nationwide campaign.

The report, entitled "Children in Migrant Families," may be obtained from the Senate Appropriations Committee, The Capitol, Washington 25, D.C.

Poison Control

The American Association of Poison Control Centers recently adopted tentative standards for centers to promote round-the-clock service, the maintenance of up-to-date data on poisonous substances and treatment, and the broadest possible dissemination of this information.

The National Clearing House for Poison Control Centers lists 421 centers, of which 377 provide treatment as well as information service, located in all but two States and every territory. The outgrowth of a poison control program begun in 1953 by the Illinois Chapter of the American Academy of Pediatrics, the first poison control center was established in November of that year in Chicago. (See "A New Life Saving Device is Launched," by Dr. Edward Press in CHILDREN, May–June 1954.)

Differentiating between information centers, which give poison information without providing treatment, and poison control centers with both information and treatment facilities, the association includes among other recommendations:

- *For information centers:* Listing the sources and the availability of antidotes; keeping records of requests for information, including name, age, address of suspected case; and type and amount of substance ingested.
- *For the poison control center:* Appointing a physician as the center's director and an alternate to serve in his absence; orienting emergency staff in treatment techniques.
- *For both types of centers:* Setting up 24-hour operations; encouraging preventive education programs in the community.

Cuban Refugees

An emergency welfare program to meet the minimum needs of Cuban refugee families and children in southern Florida, begun in November 1960 on order of former President Eisenhower, has been broadened in recent months to include Federal provision of funds for subsistence and other purposes. The action was based on recommendations of Secretary of Health, Education, and Welfare Abraham A. Ribicoff, following an on-the-spot survey of the conditions of refugees in Dade County (Miami) made in February 1961 at the request of President Kennedy.

The increasing influx of refugees from Cuba into the Miami area had led President Eisenhower to allocate $1 million for their aid out of the contingency fund of the mutual security program, to be spent under the direction of Tracy S. Voorhees, his personal representative. This assistance was channeled chiefly into defraying the costs of resettlement and of maintaining a refugee center in Miami as the hub of efforts by voluntary and State and local public agencies to provide the refugees with care, shelter, employment, and resettlement.

Producing $4 million more from the contingency funds, President Kennedy has authorized Secretary Ribicoff to develop activities to meet the minimum needs of the refugees for daily subsistence, resettlement, employment, education, and health, and for the care and protection of unaccompanied children. The Commissioner of Social Security has been delegated the responsibility of administering all phases of the program through the constituent agencies of the Department. He also acts as Secretary Ribicoff's representative with other Federal agencies involved in the program.

By April 7, more than 4,000 family and single cases received aid administered through the Florida State Department of Public Welfare with the help of Federal funds. About $352,000 of public assistance funds had been distributed to the recipients, with the payments averaging $70–$85 per month.

Through contracts with voluntary and public agencies, the State agency acts for the Federal Government in providing foster care for a considerable number of unaccompanied children.

Through an arrangement with the Florida Department of Education, the costs of providing grammar and high school education to approximately 3,500 Cuban children in the Miami area are partially paid out of Federal funds. Besides waiving school fees required of nonresidents, for a number of the needy children, Dade County school authorities are furnishing hot lunches for some of the Cuban children.

Other costs partially borne by the Federal Government are those connected with construction of temporary classrooms and the provision of adult education classes, including English-language courses, orientation to the United States, and vocational training.

On March 20, President Kennedy approved a $75,000 grant to the University of Miami to assist Cuban scholars and professional leaders in educational pursuits.

Federal loans have been made to 323 Cuban college students through 15 institutions of higher learning in the United States. The students may borrow up to $500, without interest, payable within 5 years.

Federal money also continues to underpin the resettlement work carried out cooperatively by voluntary agencies—principally the Catholic Relief Committee, Church World Service, the United Hebrew Immigrant Aid Society, and the International Rescue Committee—through payment of transportation costs and expenses associated with adjusting in the new locations. These agencies have resettled more than 1,600 Cubans from Miami throughout the country.

Also cooperating in this phase of the program are the Immigration and Naturalization Service, which has facilitated the process by which displaced Cubans accept employment; and the U.S. Employment Agency, which helps them find work. The University of Miami maintains a roster of displaced professional persons for retraining and placement.

For essential health services—including immunizations and chest X-rays for tuberculosis detection—the refugee center maintains a clinic jointly set up in 1960 by the Dade County Health Department and U.S. Public Health Service. The latter agency provides a physician who directs the work with the assistance of Cuban physicians.

By mid-April some 10,000 cases were registered at the refugee center for service under the program.

Child Welfare

Representatives from the attorney generals' offices and child welfare directors of eight States and members of the Children's Bureau staff met in San Francisco for 2 days late in February in a biregional conference on adoption laws and procedures sponsored by the Children's Bureau, for the States in regions VIII and IX. The conference was concerned with identifying the types of laws needed in regard to the termination of parental rights and the protection of children in adoptive placements; workable procedures in providing services to unmarried mothers; and ways of improving interprofessional relationships. A springboard for part of the discussion was a draft of a document being prepared by the Children's Bureau to serve as a guide for State legislation on adoption. The States represented at the conference included Arizona, California, Colorado, Hawaii, Nevada, Oregon, Utah, and Washington.

Inservice Training

A new residential center for inservice training in neighborhood social work was opened in Chicago during the fall of 1960 by the National Federation of Settlements and Neighborhood Centers. Financed during the first 3 years by a Field Foundation grant, the center occupies a wing of the Hull House, founded in 1889 by Jane Addams.

The center provides concentrated 1-week courses in specific phases of neighborhood work to settlement or neighborhood house executives, board members, experienced workers, and newcomers to the field. They focus on such subjects as: services to specific groups—ethnic minorities, hard-to-reach youth, multiproblem families, mobile populations; administration; planning and carrying out research projects; and orientation to settlement work. Classes are limited to 25 students.

Guides and Reports

ADC: PROBLEM AND PROMISE. Kathryn D. Goodwin, Peter Kasius, Kermit T. Wiltse, and Justine Fixel. American Public Welfare Association, 1313 East 60th Street, Chicago 37. 1960. 40 pp. $1.

One of a series supported by a special grant from the Rockefeller Brothers Fund, to help public welfare agencies carry out the provisions of the Social Security Act, this pamphlet contains three papers which assess the aid to dependent children program in relation to its purpose, the criticisms against it, administrative responsibilities, and future possibilities.

THE FURIOUS CHILDREN AND THE LIBRARY; by members of the staff conducting the research project at the National Institute of Mental Health and the librarian of the Patients' Library, National Institutes of Health, Bethesda, Md. *Top of the News*, 50 East Huron Street, Chicago 11, Ill. 1960. 19 pp. Minimum order, 3 copies for $1.

Presents reactions of the authors to the value of the library in the treatment of six extremely aggressive, emotionally disturbed children. Reprinted from *Top of the News* of March, May, and October 1960.

THE COURT AND PROTECTIVE SERVICES; their respective roles. Vincent De Francis. Children's Division, American Humane Association, 896 Pennsylvania Street, Denver 3, Colo. 1960. 19 pp. 15 cents. Quantity discounts on request.

This paper, published in pamphlet form, discusses the purpose and functions of two agencies—the juvenile court and child protective services—in relation to their separate and cooperative roles in the process of achieving maximum results on behalf of neglected children.

LET'S TALK WITH ADOPTIVE PARENTS: a supplement to "All About You," an adoptive child's memory book by Marion A. MacLeod. (Listed in July–August 1960 issue of CHILDREN.) C. R. Gibson and Co., Norwalk, Conn. 1959. 24 pp. Free on request from publisher.

For adoptive parents, gives some of the "why's" and "how's" of telling the adoption story to their children, in addition to suggestions for using the memory book.

WHEN A PARENT IS MENTALLY ILL; what to say to your child. Helene S. Arnstein. Child Study Association of America, 9 East 89th Street, New York 28. 1960. 47 pp. 50 cents. Quantity rates available upon request.

A guide for the parent who faces the problems that affect family life when the other parent is mentally ill.

IN THE JOURNALS

The Status of the Midwife

According to a study of midwifery as it survives in the nonwhite, rural communities of the Southeast, among formally trained and licensed midwives, the "granny" practitioners (those who are learned in the old folkway tradition) enjoy greater prestige and therefore larger practices than others. Reporting in *The American Journal of Sociology* of March 1961, the investigators find the keys to this difference in the status that comes with age and experience. ("The 'Granny' Midwife: Changing Roles and Functions of a Folk Practitioner," by Beatrice Mongeau, Harvey L. Smith, and Ann C. Maney.)

Human and Cow's Milk

Emphasizing that there is still no perfect substitute for human milk, Harold H. Williams of Cornell University's Department of Biochemistry compares its composition with that of cow's milk, in the *Journal of the American Medical Association* of January 14, 1961. ("Differences Between Cow's and Human Milk.")

He writes that human milk contains amounts of water, solids, and fats, similar to cow's milk, but only one-third of the protein and ash. Over 60 percent of the fat in cow's milk is composed of saturated fatty acids, whereas in human milk they make up less than 50 percent of the total fat content. He also points out that human milk fat has more than three and one-half times as much of the "essential" fatty acids as does the fat in cow's milk. Also, human milk has more vitamin A and less vitamins D and K.

There is nearly 10 times as much vitamin E in human milk as in cow's milk, and more linoleic acid, the author reports. The correlation of the higher content of linoleic acid with that of vitamin E is of more than passing interest, he adds. Recent studies show that increased ingestion of linoleic acid raises its content in erythrocytes and in brain tissue. Such changes, the author conjectures, are probably related causally to the vitamin E requirement. He points out that some of the striking differences in the patterns of minerals, fatty acids, vitamins, and several amino acids may be significant in the utilization of milk from one animal species by another.

Safety for the Handicapped

Rather than keep exceptional children away from environments believed hazardous, help them acquire habits that eliminate causes of most accidents associated with the handicapped, advises Ernest P. Willenberg, in the February issue of *Education* ("Safety Education for Exceptional Children"). The author, who directs the special education activities in Los Angeles city schools, suggests that school program planners use an ecological approach to the problem. Factors he mentions as likely to need attention in the child include his general mobility, use of visual or auditory perception, level of knowledge, kind of attitudes, quality of judgment, and use of skills. He also recommends strengthening resources for the child in the environment to compensate for hazards imposed by the handicap.

The series, a project of the National Safety Council and the Council for Exceptional Children, is also appearing in the periodical, *Exceptional Children.*

The Child's Potential

Aldous Huxley, writing in the *Bulletin of the Menninger Clinic* of March 1961, takes today's educators to task for failing to pass on to children what we have learned in the 20th century about the nature, limitations, and—through its "misuse"—the persuasive power, of language. ("Human Potentialities.") He wonders whether experimental training in semantics begun in childhood could bring out potentialities that would otherwise lie "buried under unexamined preconceptions and traditional notions or smothered by uncritically accepted propaganda."

Words used skillfully can arouse zeal, which, especially if aggressive, has the effect of a psychosomatic "pick-me-up" says the British author. Quoting William Blake, "Damn braces, Bless relaxes," Huxley asks how we can make the life of reason and kindliness "as thrilling as the life of crusading unreason."

Education, in his judgment, also fails to take into account the degree of variability in the human race, which is greater, he believes than in other species. He finds it absurd to herd creatures dissimilar temperamentally and in general ability and special gifts into one classroom for the same kind of intellectual, emotional, and ethical training.

Conceding that there is no other course at present, he foresees the day when we will think in terms, not of brute quantity, but of quality, when we will recognize, respect, and make the most of the enormous spread of human diversity.

Residence as a Privilege

How an open institution for disturbed adolescents who are mostly borderline delinquents manages to keep these young people in residence—and out of the training school—is outlined by Harry Finkelstein in *Social Casework* for March 1961. ("Containment of Acting-Out Adolescents in an Open Institution.")

In the Children's Home of Baltimore, of which the author is executive director, treatment of 30 boys and girls revolves around the philosophy that residence there is a privilege—the violation of which can mean commitment to a training school—rather than a period of compulsory confinement. About one-third of the group, with histories of stealing, firesetting, and sexual promiscuity, came from a training school; the rest because of behavior difficulties were removed from their own or foster homes.

Describing how the home has been transformed since 1957 from a custodial institution to a treatment center, the author emphasizes that its setting—a middle-class, residential neighborhood, whose public schools, churches, and recreational facilities these adolescents use—and the nearby bus stop—necessitate limiting admission to those who want to stay. This desire to remain, he points out, can be the fulcrum of power in helping the child build up inner controls or otherwise to curb antisocial behavior, and he draws on a number of case histories to illustrate the point.

READERS' EXCHANGE

LEMKAU: *Difficulties with parents*

Dr. Lemkau clearly points out that compassion dictates "the maximal use of normal channels of input" for stimulating the handicapped child. ["The Influence of Handicapping Conditions on Child Development," by Paul V. Lemkau, CHILDREN, March–April 1961.] Unfortunately, it is often the parents' misunderstanding and use of compassion which serves as a barrier to children being offered the stimuli which they need. One of the outstanding problems of the handicapped child lies in the parent who feels that the child is unable to perform and who therefore continues to carry out activities for him at an age when he should be learning for himself. Such an attitude of overprotection growing out of the concern that the parent has for the child, as well as a feeling of not having provided well for the child initially, leads to the type of deprivation of which Dr. Lemkau speaks.

Experience shows that it is not easy to convince such parents that they are in any way depriving their child. The question to the clinician is nearly always, "What more can I do?" The suggestion that they do less in the way of assisting and more in the way of offering to the child self-stimulating activities is often difficult for them to understand.

Dr. Lemkau demonstrates that true compassion for a handicapped child is best expressed by providing him with challenges, even hazards. To convince parents that this is the proper thing to do becomes increasingly difficult the longer they are accustomed to helping the child with the daily activities of life.

In an ordinary child the lack of a learning experience at the time when the child is ready for it leads to a deficit which can impair development. As Dr. Lemkau points out, the same kind of deficit may occur in the handicapped child if the stimuli which would provide the opportunity to learn are missing. The parents have an outstanding role in the provision of these stimuli. It becomes therefore an important clinical task not only to make the parents aware of the opportunity to provide such stimuli but to relieve them of the feeling that they are not doing all that they can to assist the child when they must force him into a necessary activity in what may seem to them a rather incompassionate way.

Henry H. Work
Department of Psychiatry, School of Medicine, University of California Medical Center, Los Angeles

Stimulation in nursery schools

One cannot read Dr. Paul Lemkau's penetrating article without increased compassion and insight regarding the effect of handicaps upon a child's development. His clarity in presenting concentrated scientific data makes a fresh and stimulating impact. While it is true that "knowledge and informed theory can keep compassion working at maximal efficiency," conversely, fuller understanding of the deprivations, complexities, and frustrations of handicapped children increases one's compassion and desire to help.

Particularly arresting is the thought that just as an eye deprived of light reacts by becoming useless, so may the whole child respond to lack of wide-range stimulation by becoming inert. Where there is decreased sight or hearing, not only is the individual deprived of basic experiences but the integrative function of the brain, which adds meaning to experience, is also understimulated.

Recognition of the need for adequate stimulation has helped counteract the earlier tendency to overprotect and hence limit unduly the experience of children with handicaps. Realization also that optimal opportunity for stimulation is essential in the early years has also led to the development of play groups and nursery schools for children with similar handicaps in vision, hearing, or movement.

Even more salutary may be the practice, which has been found highly valuable in some cases, of including a blind or deaf or palsied child in a nursery school for normal children. This plan has been less successful for children with mental or emotional handicaps.

Weekly observation classes for parents of retarded children, where each parent watches her preschool child interact with a group guided by a trained teacher, have been very successful, however, and have led to the formation of cooperative nursery centers for these children.

It is found in these groups that mentally handicapped children also gain from the stimulation of seeing other children and of using richer play equipment than many homes provide. Such guided observation and cooperative nursery groups have the added values of helping parents gain needed insights and skills for carrying on wisely at home and of providing emotional support from the other parents facing the same problem.

Katharine Whiteside Taylor
Supervisor of Parent Education, Baltimore Public Schools

PEAY: *What is cardiac neurosis?*

In commenting on my article, "The Emotional Problems of Children Facing Heart Surgery," in the November–December 1960 issue of CHILDREN, Marilynn Willner was certainly right in stating that there is a lack of and great need for research in the area of emotional problems of children with congenital heart disease. [CHILDREN, March–April 1961, page 80.]

Her comments about the continued cardiac neurosis in children in early adolescence seen at the medical center at the University of California at Los Angeles made me think a little more specifically about my own brief reference to the little "cardiac neurosis" we see in postsurgical children. Realizing that we both italicized the words, I began to wonder if we were both reacting to a similar definition of the words "cardiac neurosis" or if we perhaps each had our own understanding of this term.

I know of few, if any, studies in this area, but to pursue research here would certainly necessitate at least a working definition of what is meant by cardiac neurosis in children. How and when do we determine whether cardiac neurosis follows successful surgery, when there are so many presurgical contributing factors to the children's behavior and attitudes? Such factors include the length of the illness, the type of congenital defect (Tetralogy of Fallot or Patent Ductus Arteriosus), the symptomatology, the life-threatening aspects of the condition, the degree of limitation on the child's activities, the parental care required, and so on.

I am glad Miss Willner commented on this particular point in my article because it made me take another look at my use of the term "cardiac neurosis." What *do* we mean when we say there is or is not cardiac neurosis following surgery?

Roberta Peay
Clinical Social Workers, National Institutes of Health

THOMAS: *No sacrifice of asepsis*

After reading Miss Thomas' article "Conflicts in Protecting the Newborn in Hospitals" [CHILDREN, May-June 1961], as a nurse who works in a hospital nursery I find myself asking the following questions:

- Is it necessary to sacrifice either the aseptic aspect or the psychological aspect of care?
- What has happened to the principles of aseptic techniques which we learned as students, and which proved effective before the advent of antibiotics?
- Has the nurse lost all the qualities which enabled her to give psychological support to the patient and her family?

I believe that no chance for spreading infection should be taken by permitting even one father into an area so important to the welfare of mother and infant as the delivery area, nor should groups be permitted to tour the delivery area. We do know that the more traffic in and out of an area, the greater chances are for contamination. Visitors to the obstetric division should be restricted for the same reason. However, whenever such restrictions are placed on families, mothers should be informed of the reasons for this early in the prepartal period.

Having a baby is probably no more traumatic than undergoing an operation. Do we invite husband, father, or mother into the operating room during an operation or into the recovery rooms following it? Do we invite prospective patients to tour the operating rooms? Asepsis is just as important in the delivery rooms as in the operating room, and psychological support is just as important to the patient undergoing surgery as to the mother having a baby.

"Rooming-in" would probably reduce chances for spreading infections, if true and complete rooming-in were practiced. However, I question the effectiveness of such halfway practices as permitting the infant to be with the mother and father during the day and then returning all infants to a central nursery at night. Such a practice would only increase the chance for spread of infection.

Because of the beneficial effects to both mother and baby, breast feeding should not be discouraged. Where cleanliness and aseptic principles are carried out both in the nursery and in the mothers' units, there would seem to be little danger in this.

Many questions need answering before definite statements can be made about advisability of wholesale early discharge. They include:

- Where do the organisms come from?
- What factors exist in those hospitals which report infections that are conducive to infection?
- Why do these conditions exist and what can be done about them?
- Why can't the person who takes care of the mother's children while she is in the hospital continue to help her care for them at home if she is discharged early?
- How available is public health followup to mothers discharged early?

Cleanliness is of prime importance in combating the spread of infections and must not be sacrificed under any condition.

Simple and adequate procedures for providing both aseptic and psychological aspects of care require understanding and cooperation by all persons involved in the care of mother and infant.

Mary M. McNeer
Supervisor of Nurseries, District of Columbia General Hospital

PAGE: *More of same needed*

I have just read Miriam Page's article, "Cohesion, Dignity, and Hope for Multiproblem Families," [CHILDREN, March–April 1961] and I find myself not only interested but also inspired by its contents. All over this country in small cities and towns there are families such as those Miss Page describes. They tend to group together in neighborhoods of rundown houses and shacks in the least desirable part of town. The rest of the community expects problems from these people, tends to overlook infractions of community standards until they become too disturbing, and does not anticipate improvement in their way of life. Perhaps most serious, the children of these families are not expected to rise above this level of living, and they often are treated accordingly. To see social workers recognizing this situation and wholeheartedly trying to do something about it in any locality is encouraging.

The second significant fact to which I would like to call attention is that it is the public welfare agency that is responsible for this effort. For most rural areas the chances for the development of the urban variety of professional social services supported by private funds are negligible. The best hope for obtaining the kind of social service needed is through placing community support behind the strengthening and broadening of the public welfare program. This Vermont effort, jointly supported by public welfare and a foundation, illustrates what can be accomplished through this approach.

The third fact that impressed me was the willingness of the welfare department and of the workers themselves to do what had to be done to help these families and their little community toward better living. Obviously, it would have been desirable to have drawn upon volunteers or other professional services for some of the leadership needed. When such assistance did not materialize, however, rather than let the activities fail and the people of the neighborhood suffer another defeat, these workers filled various leadership gaps themselves. Starting out with an effort to provide casework, they soon found themselves deeply involved in community organization and finally in group work activities. Throughout, however, the goal of helping individual families and the casework effort was maintained.

Rural areas need more workers with the zeal of these people, more public welfare agencies with the flexibility to experiment, and more foundations willing to support such efforts.

Maurice O. Hunt
Director, National Survey Service, New York

U S GOVERNMENT PRINTING OFFICE: 1961

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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PARENT EDUCATION AND THE BEHAVIORAL SCIENCES; relationships between research findings and policies and practices in parent education. Armin Grams. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 379. 1960. 52 pp. 25 cents.

This publication is a summary of the 1958 parent education conference jointly sponsored by the Children's Bureau and the Institute of Child Development and Welfare, University of Minnesota. It summarizes the major issues discussed by research specialists which resulted in a listing of the research problems that emerged during the conference in the field of parent-child relations, child development, and family interaction.

CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN; a listing. Rudolf Hormuth. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960. 28 pp. Single copies free on request.

This third and revised listing of special clinical facilities throughout the United States for mentally retarded children, provides information about the types of facilities reported, where they are, and who directs them. No evaluation is made of the quality of services rendered. The information reported in the listing was provided by the clinics.

SUPPORT FROM ABSENT FATHERS OF CHILDREN RECEIVING ADC, 1955. Saul Kaplan. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. PA Report No. 41. 1960. 112 pp. 65 cents.

Final report of a survey of ADC families with absent fathers, conducted by the Bureau of Public Assistance in 1955. (See CHILDREN, March–April 1958, p. 74.) Major highlights of these findings appeared in the *Social Security Bulletin* of February 1958. The current report includes details about the States and analytical findings not previously published.

JUVENILE-COURT STATISTICS—1959. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 61. 1960. 18 pp. Single copies free.

The year 1959 showed the lowest annual increase in reported court cases of juvenile delinquency in the past decade according to this bulletin. Contrary to the trend in other years, this increase of 2 percent was lower than the increase in child population. Delinquency cases handled in urban courts fell 2 percent; while those in semiurban and rural courts increased by 7 and 15 percent, respectively, following the pattern for all three types in previous years. However, the semiurban and rural courts, the report points out, handle only about two-fifths of all the court juvenile delinquency cases in the Nation.

CHILD WELFARE STATISTICS 1959. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 60. 1960. 32 pp. Single copies available from the Bureau without charge.

Presents statistics in tabular form on children receiving child welfare services from State and local public welfare agencies; personnel in these agencies; selected expenditures for public child welfare services; and adoptions. Highlights of the data are interpreted in a section preceding the publication's 27 tables.

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Youth in the Carribbean

Parents of the Handicapped

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◀

ANTICIPATION. These youngsters, gathered on a Philadelphia sidewalk, are awaiting the appearance of the Play Parade, a mobile unit equipped with toys, games, craft materials, and volunteer teenage recreation leaders, due in their block for the day. The trailer is part of a group of similar units which, under the auspices of the Friends Neighborhood Guild, a United Fund community center, move through this "inner city" neighborhood in the summertime to bring constructive fun to children whose playground is the street.

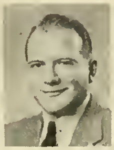
◀ *the authors*

In addition to serving with the Jewish Family Service, which he joined 5 years ago, Dr. Nathan W. Ackerman holds the posts of clinical professor of psychiatry at Columbia University and lecturer at the New York School of Social Work. He also directs the newly organized Family Institute described in his article. Previously, for 14 years, he was chief psychiatrist with the Jewish Board of Guardians, New York, and director of its Child Development Center.

The activities for parents of handicapped children described by Aline B. Auerbach are part of the latest in a series of programs conducted by the Child Study Association to train professional workers—in this case, social workers—to serve as leaders in parent education groups. The author, who has done graduate work at Columbia University's Teachers College and the New York School of Social Work, is a specialist in parent education and has written numerous pamphlets and articles for parents and professional workers.

Carol H. Meyer joined the New York City welfare department after 4 years on the faculty of the New York University Graduate School of Social Service. A former caseworker with the Community Service Society, she focused her interest in family diagnosis before going into public welfare. She has both a master's and doctorate from the New York School of Social Work, Columbia University.

Since receiving his Ph. D. in psychology at the State University of Iowa, John H. Rohrer has been doing experimental studies on social learning and on interrelationships between culture and personality, and, in recent years, on personality disorders. When directing the study described here, he was heading the Urban Life Research Institute for Tulane University. He joined the staff of Georgetown University School of Medicine in 1957.



Prior to coming to the Children's Bureau in 1949, Martin Gula directed a treatment residence for disturbed children and, before that, an experimental diagnostic and treatment center for adolescent boys. He has also been rural social worker for a State welfare agency, a psychiatric clinic caseworker in a State training school, a settlement house worker, and a faculty member at the schools of social work at Loyola University and the University of Chicago. He has graduate degrees in both social work and education.

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YOUTH IN THE CARIBBEAN —REACHING FOR MATURITY

KATHRYN CLOSE

ARE ADOLESCENTS in a Caribbean island the same as anywhere else in the world? This question kept intruding itself into the Conference on the Adolescent in the Changing Caribbean, held April 4–11, at the University College of the West Indies, Mona, Jamaica. Among the 198 participants, 20 of them adolescents and young adults, from 12 Caribbean islands and the continental United States, the consensus seemed to be "yes," but—except perhaps among the young people themselves—a "yes" qualified by recognition of the differences created by cultural expectations, by opportunities, and by frustrations. More than once it was suggested that psychological adolescence in itself is a new phenomenon, created by the industrial revolution and intensified in areas where old cultures are giving way to new, with resulting conflicts among the generations.

This conference, the third Caribbean conference for mental health, was a sequel to the Conference on Children of the Caribbean—Their Mental Health Needs, held 2 years ago in St. Thomas, U.S. Virgin Islands, under the auspices of the World Federation for Mental Health and the Virgin Islands and Puerto Rico Governments. The Virgin Islands conference had resulted in the formation on the spot of the Caribbean Federation for Mental Health and later of the Jamaica Association for Mental Health, the cosponsors of this year's meeting. The First Caribbean Conference for Mental Health, held in Aruba, Netherlands Antilles in 1957 was focused on alcoholism.

The question might be raised as to why a mental health conference in the Caribbean. What do these scattered islands of the Greater and Lesser Antilles, some of them more than a thousand miles from each other, have in common besides their tropical beauty? Not language. Four different languages—English, French, Dutch, Spanish—were the official languages of the islanders who attended the conference. Not political structure. Haiti was the only completely independent country with participants at the Jamaica conference. The islands of the West Indian Federation, represented there by Jamaica, Trinidad, Barbados, Dominica, and Antigua, are soon slated for independence. Puerto Rico is a commonwealth economically and politically tied to the United States; the U.S. Virgin Islands is a territory of the United States; Martinique and Guadeloupe are Departments of France; Curaçao and Aruba are linked to the Netherlands in defense and foreign policy. (Cuba and the Dominican Republic, also invited to the conference, did not send representatives.)

What all these islands have long had in common is widespread poverty, a rapid population increase, a low level of education among the masses of the people, and a heritage of mixed cultures strongly influenced (except in Puerto Rico) by the African origins of the great majority of the people and the insults of slavery and its aftermath. What they have in common today, in addition, is an obvious ferment among the people, especially the young, to partake of the good life and to run their own affairs. One of the most frequently repeated phrases at the conference was "the rising expectations of the masses." Whether these expectations are to result in healthy achievement or frustration and despair, and perhaps even explosion, was the haunting question that throbbed like a drum accompaniment throughout the conference.

The structure of the conference included daily plenary and work group sessions, the latter mixed professionally and nationally, and a few intraprofessional meetings. While a few "outside" experts from England, Canada, The Netherlands, and the United States spoke at the plenary sessions and served as consultants and leaders in the group meetings, the large majority of speakers and other participants, were islanders—psychiatrists, medical practitioners, nurses, social workers, educators, sociologists, psychologists, anthropologists, government administrators, clergymen, law enforcement agents, and students. In this respect, the conference was, in fact, more truly a Caribbean conference than its Virgin Islands predecessor.

This was the first of the three Caribbean mental health conferences to invite young people as participants. The 20 young men and women—all students at secondary schools or universities—were self-possessed and articulate, speaking out unhesitatingly about the problems bothering them, and often exerting an influence to keep the conference action-oriented. While perhaps they represented only the well-educated "cream" of young people in these economically depressed islands, they at least knew what *they* wanted. Most persistent of their cries: "Give us more freedom so that we can become independently responsible."

So many psychiatrists attended the conference that the visitor's first impression was apt to be that psychiatrists are plentiful in the Caribbean area, until he realized that some countries had sent *all* their psychiatrists to the meeting—in the case of Haiti, for example, two. Yet there was little talk of isolated psychiatric theory. The Caribbean psychiatrists, as well as other professional people of the islands, were obviously culture conscious, their concern being how to ameliorate the conditions in the island cultures that prevent the healthy development of adolescents.

When the psychiatrists did discuss treatment techniques together, they talked about ways of adapting what they had learned "elsewhere" to their patients in the islands. For example, among a people immersed in magical cults how is it possible to tell where superstition ends and hallucination begins? In Haiti, it was reported, the psychiatrist must sometimes work through the voodoo priest.

The assumption of the conference was that psychiatry cannot solve the mental health problem alone, that the major task of preventing mental and emotional disturbance can best be accomplished by spreading mental health understanding and techniques among those who come in daily contact with parents and children. A few participants even expressed the opinion that mental health—which a Dutch psychiatrist [1] defined as "the promotion of optimal living"—was not the job of psychiatrists at all, but of psychologists, sociologists, teachers, and even voters, who must bring about conditions conducive to healthy living.

Adolescence

Descriptions of adolescence per se came from many sources—psychiatrists, psychologists, anthropologists, educators, public health nurses, and community development workers. There seemed to be general agreement that adolescence today is a period of "sturm und drang," a time when the young person is reaching out for freedom, but still needs the security of his parents' affection, when sexual urges are strong, a time when friendships are extremely important, when adult models have a critical influence on the shape of things to come, and when the need to feel needed in the world is paramount.

Over and over the point was made, by experts and by adolescents themselves, that much of the adolescent's inner confusion is created by adults who tell him he is "acting like a child" but will not give him the independence of an adult. Psychiatrists, psychologists, and anthropologists emphasized the importance of the young person's having a delineated role—of, as a Chicago psychiatrist [2] expressed it, his "knowing who he is and where he is going"—and they pointed to the failure of the modern world to provide this.

An educator from Jamaica,[3] on the other hand, maintained that in the "solitary" struggle to grow up, an adolescent must find his own way and "have the opportunity to make mistakes." This seemed to cause considerable anxiety among some of the conference participants concerned with the obligation of adults to guide the young. A community development worker from Trinidad [4] asked whether there were not such things as truth, freedom, justice, sexual morality, "about which we adults cannot allow experimentation." A medical student from the university [5] commented that the method of trial and error was too hard a way to learn. And an educator from Antigua [6] warned the young people present to use their reason, to try new things, but to control their impulses and mistrust their experience, and to draw on the experience of older people.

However, a Virgin Islands high school student [7] responded by maintaining that a young person must have enough self-confidence to be able to say to himself, "I can be right, he can be wrong."

VIRGIN ISLANDS
PUERTO RICO
ANTIGUA
GUADELOUPE
HAITI
DOMINICA
MARTINIQUE
JAMAICA
BARBADOS
CURAÇAO
TRINIDAD
ARUBA

Time and again in the discussion groups young people expressed a sense of dissatisfaction with their elders in such remarks as: "Our parents don't trust us," or "Young people look to adults for direction, but adults seem to need direction."

Cultural Influences

Thus, much of what was said would apply in New York, New Orleans, or Peoria, Ill. But inevitably, just as the observer was beginning to feel that he was back at the 1960 White House Conference on Children and Youth, the special circumstances of being an adolescent in the Caribbean would emerge. It became clear that while these were similar in most of the islands, they were not exactly the same. For example, a psychiatrist from Aruba[8] reported that in his island the entire process of adolescent development is shorter than in most Western countries; but in Haiti, according to a psychologist,[9] the parents tend to prolong adolescence by keeping young persons dependent upon them until they are nearly 20.

In all the islands, it became apparent, young people are faced with conflicts between old layers of cultures within the islands as well as between the old and the new. These Caribbean islands in the course of history have been passed from nation to nation, with the result that in many of them a variety of European cultures have been imposed upon the descendents of the people brought from Africa. For example, a social worker reported[10] that among the middle classes in Curaçao both the Spanish strictness with the young and the more lenient Dutch attitudes have persisted, to the confusion of young people and their parents alike. In the lower economic groups, the woman is usually too overburdened to have time and energy for supervision of the young, she added.

There were a few who maintained that the great majority of Caribbeans of African descent had never truly assimilated the overlays of European culture. The Aruban psychiatrist[8] said that the European arts, philosophy, and religion have penetrated very little because they do not give enough emotional satisfaction to the people. The young Caribbean, he said, learning one thing at home and another at school, develops a kind of "double super-ego," the two parts living independently, unintegrated and often disputing each other. He saw signs, however, in the new surge for independence, of a reorientation of the adolescent to new norms and new values not requiring the loss of the young person's own nature.

The poignancy for young people of the conflict in culture values came out clearly in another psychiatrist's[11] analysis of attitudes in the Virgin Islands toward sex. The adolescent of the lower classes there, he said, because of "historical and environmental influences" has been rather removed from the inhibitions on sexuality imposed by Western society. Unmarried girls gladly fulfill the function of motherhood without being stigmatized, he maintained. There is a pride, among both sexes, in producing progeny, he said, but little tenderness between sex partners, though the girl longs for marriage to achieve status. While these young people are beginning to doubt past values, he added, they are suspicious of the new ones to which they are exposed. Saying that psychiatry has no ready answer for them other than to help them reach their own "self-rearrangement of meaning," he suggested that an intensive study of the psychodynamics of "fathering" be undertaken, and that the findings of this be conveyed to adolescents.

Fathering

The matriarchal—often fatherless—family received much attention at the conference. Evidence was presented indicating that in all the islands, except Puerto Rico, this type of family is common in the lower economic groups, with the male being regarded as hardly more than an impregnator and an unreliable means of support. Because fathers often wander off, whether from a marriage, a consensual union, or a casual affair, many young women are left with a number of children to support and in order to have some help in this, take up with another man.

Whether the reasons for this go back, as the Virgin Islands psychiatrist [11] suggested, to customs enforced in slavery days or brought over from Africa, or, as a Jamaican anthropologist [12] maintained, lie chiefly in the inability of men to find steady employment, the result is often a passing around of children to grandmothers and other relatives and a lack of any sustained male adult model in the family.

While the question was raised, with superficial levity, as to whether fathers were really needed, since so many people in the West Indies have grown up without them—"and still we are creating a new nation"—the psychiatrist from Trinidad [13] who raised it provided an earnest answer, that children need fathers in adolescence more than at any other time. However, he too suggested the need for more studies on the effects of "paternal deprivation."

Repeatedly one heard references to persons who served or might serve as substitute fathers—older brothers, the mother's father or brother, a godparent, the mother herself, a community representative, such as a teacher.

The importance of the father figure to the child seemed to be generally accepted with a kind of pessimism about the possibilities of achieving this for every Caribbean child. One discussion group reported as a point of consensus, "Half a father is better than none."

Racialism

A kind of bombshell was dropped in the inaugural session of the conference when the featured speaker, a social psychologist from the United States,[14] devoted a large portion of his speech to a discussion of racial discrimination and its effect on mental health—a bombshell at least to an observer from a land where discrimination is much more evident than in the West Indies. But the purpose of the emphasis became clearer as the week went on.

While racial segregation is generally absent, persons living in the area pointed out, an insidious kind of discrimination based on color and shade, practiced even within families, operates against the opportunities of some young people to achieve educational opportunities, suitable employment, and social status. An American anthropologist [15] noted, however, that, as the West Indies moved toward independence, achievement, more than color, was becoming the indicator of status.

The inaugural speaker [14] also referred to "racialism in reverse," a growing hatred of whites observable in many countries today, and warned that "racialism" is bad mental health no matter who is practicing it. This point, however, was challenged by a West Indian sociologist,[16] who said that as oppressed groups move into different positions they can be expected to take racist attitudes, "but these should pass eventually except in sick personalities."

The Changing Scene

This shift in positions of discriminator and discriminatee was but one of many changes in the Caribbean mentioned. Most talked about was the political move toward self-determination—especially in the islands of the West Indian Federation—and its personal counterpart in the urge of masses of young people for self-realization. Others were the rapid industrialization of Puerto Rico, the growth of tourism as an industry, the flocking of young people from the rural areas to the cities, and the mass emigration of West Indians to Great Britain and of Puerto Ricans to the United States—all factors in the rising expectations of the masses as well as in family disruption and conflict between the generations. In Barbados, it was pointed out, the population pressure is so great that the government is paying young people to emigrate to England.

There was some decrying of standards "brought from abroad" [16] and of reliance on "Yankee ideas," [17] as well as expressions of fear that tourism would bring segregation patterns and a spread of servile attitudes.

How misleading the transplanting of foreign developments can be was demonstrated by a psychologist from Haiti [9] in telling of the difficulties of measuring the intelligence of illiterate Haitian children

Rita Varela, youth delegate of Puerto Rico, speaks to the conference on adolescents in the changing Caribbean. The others are, left to right: Dr. Guy Benoit, psychiatrist, Guadeloupe; Beverly Moyston, social worker, Jamaica; Eldra Shulterbrandt, psychologist, U.S. Virgin Islands.

with tests developed in Europe and North America. These children, he said, often confuse the psychologist with a voodoo priest, and have strong superstitions which predispose them to answering some questions in a manner that may seem on the surface illogical. He suggested the development of clinical instruments more adapted to the culture.

From a broader view, a West Indian sociologist[16] urged the islands to take more "local initiative" in solving their economic problems and labeled Puerto Rico's 20-year-old industrialization program, Operation Bootstrap, an "Operation Retreat" because it depended on capital from the United States.

Operation Bootstrap, however, was defended by spokesmen from Puerto Rico though they did not ignore the human problems that industrialization brings. A Puerto Rican psychologist[18] said that the program represented retreat only from illness, poverty, and "outmoded nationalism." However, he pointed to a loss of communal cohesion in new housing developments, a widespread relaxing of parental standards, and a prevalence of personal anxiety as evidence that organization for community purpose must be a part of socioeconomic planning.

The changing family structure in Puerto Rico was referred to many times. Operation Bootstrap in the early years, it was reported, had emphasized light industries where the skills of women were needed more than of men. This has meant that in many families the woman has become the chief or only breadwinner, thus undermining the authority of the father, traditionally strong in Puerto Rico. In some families the father emigrates to the United States for as long as 5 months a year to work in agriculture.

The result of these changes, according to a Puerto Rican psychiatrist,[19] is widespread family distegration, increased juvenile delinquency—a 77-percent increase of court cases over the past 3 years—and an uncounted number of emotionally disturbed children and adolescents. He proposed the utilization of psychiatric centers to train personnel from all professions in the techniques of helping anxious people.

While considerable concern was expressed in discussion groups throughout the week over ways of instilling moral standards, only a few specific reports on juvenile delinquency were presented during the conference, and what figures were given could not be regarded as comparable from island to island. Nothing was presented from the other islands, however, to equal the rise in court cases reported from Puerto Rico.

A psychiatrist from Martinique[20] reported a higher incidence of thefts and "fugue states" among young people in that island than in France, putting the blame on a "passive spirit of unconcern" caused by the child's understanding very early in life that his efforts to rise from poverty will be in vain. A Jamaican social worker[21] maintained that overcrowding had a lot to do with the property and sex offenses of children who come before the courts in Jamaica. A medical officer for an oil company in Trinidad[22] reported more trouble from the "bored" children of the management staff than from a group of less privileged youngsters employed in the company's apprenticeship program.

Hopes and Fears

All during the conference one heard of the great aspirations of the young, reflected especially in what sounded almost like a mad scramble for education.

"I'm going to be a psychiatrist if it takes me until I'm 90," said a Jamaican high-school girl. And a high-school boy from the Virgin Islands explained the educational steps he expected to take to become a nuclear physicist.

These were middle-class youngsters, but high educational aspirations were also reported as held by thousands of young people of the lower socioeconomic groups throughout the Caribbean and especially in the islands of the West Indian Federation. Educators from these islands all told the same story of young people aspiring to a university education regardless of ability.

"Education is the young person's passport out of the lower social structure," said an Antiguan educator.[6] A welfare worker for the Jamaican sugar industry [23] said that young people in rural areas did not want to stay to be caneworkers, even when the company built new housing. A survey reported from Trinidad found that only 3 in 1,200 youngsters wanted to go into agriculture.

What some of the young are up against in achieving their education was indicated in a report of a study made in Antigua.[6] In answer to a query about the main problems affecting the lives of secondary school pupils, teachers and pupils alike frequently mentioned: (1) worry about a future job; (2) lack of light and space for study at home; (3) poor school plant; (4) shortage of recreational facilities; (5) poverty; (6) and lack of time for study at home.

The realities behind item 2 were made clear by a single sentence in a report of one discussion group: "Ideally a home should have two rooms, so that the children don't have to witness their parents' sexual intimacies."

That the pressure to learn may be taking a toll in mental health was indicated by a Jamaican psychiatrist [24] who reported that of 162 persons seen in a psychiatric clinic for adolescents during the past 5 years, 71 were suffering from "anxieties due to educational distress." A medical student [5] from the university, in reporting on a group of 50 young people he had worked with in a housing project (with the "ideal" two rooms to a family—sometimes of 7 or 8 people), gave a picture of the hopelessness of those who do not make the educational grade. Dissatisfaction with their jobs and feelings of helplessness were characteristic of these young people, all of whom had had to leave school by the age of 16.

There was obvious consternation on the part of a great many adults—particularly educators—at the height of the ambitions of the young. "They all want to be doctors" was a frequent comment. "Nobody wants to work with his hands," said an educator from Jamaica.[25] "We must teach young people the dignity of hard labor." Efforts were reported to lift the status of vocational schools among young people by calling them technical high schools and including them in sports competitions with the academic schools. But a great deal of worry was expressed in group discussions lest many more persons become educated to expect white-collar jobs than the job market could absorb.

Reporting on a study of career aspirations of secondary school students in Trinidad, an American anthropologist [15] pointed out that in government-supported schools, the majority of both boys and girls aspire to occupations requiring a university degree. She also reported "a positive relationship between high personal ambition and desire to help one's community" in all but the white students.

Warning against the dangers to society of allowing such widespread ambition to be frustrated, she suggested that in addition to guiding young people into the technical professions needed for economic development, the islands create a youth corps, similar to the U.S. Peace Corps, to work in community service at home. Trinidad, she said, has already used the services of young people in the rehabilitation of a slum area.

In a similar vein a Chicago psychiatrist [2] suggested that youth in the Caribbean is needed to carry on the task of creating a better society.

Suggested Action

What did it all add up to? From the beginning this was an action-conscious conference, each of the 11 discussion groups being charged with drawing up recommendations for promoting the mental health of young people in the islands. These were summarized at the final plenary session, where, in addition, a member of each discussion group presented a brief report of its priority recommendations.

Some of the groups included in their reports observations that many of the problems confronting young people in the Caribbean today stem from the widespread poverty and unemployment. One group "implored the governments" of the islands to proceed with economic development, but warned that economic advance is inevitably accompanied by social problems.

Most of the priorities stressed some form of family life education. They included:

- The stimulation of discussion groups between adolescents and adults.

- Systematic research in the various islands to determine the nature of young people's problems, with the results being made available to families.

- A community educational program, directed at both adolescents and adults.

Other priorities included vocational guidance in the schools, apprenticeship programs, improvement and spread of technical schools, sex education in the schools, and efforts to bring school teachers a greater understanding of mental health and the nature of adolescence.

In the total recommendations, improvements in education, vocational guidance, and family life education received strongest emphasis. Youth discussion groups and recreational programs were also emphasized. Four groups suggested youth corps.

There were a number of indications that these recommendations would not just gather dust. First, there were such remarks as "when I go home I'm going to start a youth discussion group in my neighborhood," or "I'm going to try to get some youth volunteers to work in my boy's club." Then there were the accomplishments since 1959 reported by the nine mental health associations represented at the conference—those of Aruba, Barbados, Curaçao, Haiti, Jamaica, Martinique, Puerto Rico, Trinidad, and the U.S. Virgin Islands—and the report that Guadeloupe has an association in the making.

Among the great variety of achievements these associations reported were: a survey to determine vocational guidance needs (Aruba); establishment of a center for delinquent boys (Haiti); organization of six local mental health clinics (Martinique); holding community forums to discuss healthy ways of living (Puerto Rico); successful efforts to have the mental health law revised (Trinidad); carrying on a newspaper column on children (U.S. Virgin Islands); and, of course, playing host to the Third Caribbean Conference for Mental Health (Jamaica).

Youth at the conference, scattered in the 11 discussion groups, spoke up chiefly as individuals, but the collective voice of youth was heard at the beginning and at the end. At the first morning session a Puerto Rican high school girl [26] reported on the views of 300 high school students "of poor and middle-class families" polled by the youth committee of the Children's Commission of Puerto Rico. Among the top needs these students had identified were: enlargement of scholarship programs for "high-level" studies; more vocational schools; and guidance programs for high-school students. But they had also asked for programs of family life education and counseling for heads of families.

The final words of the conference came from a youth participant reading a statement for the entire youth group. It ended, ". . . if, as we grow, more and more responsibility is gradually shifted to us, surely we will soon be able to decide even major matters for ourselves."

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[1] H. C. Rumke, M.D., professor of child psychiatry, University of Utrecht, The Netherlands.

[2] Bruno Bettelheim, M.D., professor of psychiatry, University of Chicago.

[3] Rev. Lewis Davidson, Principal, Knox College, Jamaica.

[4] C. R. Ottley, Director of Community Development, Trinidad.

[5] W. R. Wong, medical student, University College of the West Indies, Jamaica.

[6] Christopher O'Mard, Assistant Inspector of Schools, St. John's, Antigua.

[7] Evans Harrigan, student, St. Thomas, Virgin Islands.

[8] F. E. A. Blom, M.D., psychiatrist, Aruba.

[9] Emerson Douyon, Director, Centre d'Orientation, Port-au-Prince, Haiti.

[10] Anna C. Winkel, social worker, Curaçao.

[11] J. Herbert Fill, Clinical Director, Bureau of Mental Health, St. Thomas, Virgin Islands.

[12] Edith Clarke, anthropologist, Jamaica.

[13] Michael Beaubrun, psychiatrist, St. Ann's Mental Hospital, Trinidad.

[14] Otto Klineberg, professor of psychology, Columbia University, New York.

[15] Vera Rubin, Director, Research Institute for the Study of Man, New York.

[16] Lloyd Braithwaite, senior lecturer in sociology, University College of the West Indies, Jamaica.

[17] M. G. Smith, senior lecturer in sociology, University College of the West Indies, Jamaica.

[18] E. Sanchez-Hidalgo, professor of psychology, University of Puerto Rico.

[19] E. D. Maldonado Sierra, Executive Director, Puerto Rico Institute of Psychiatry.

[20] Michel Ribstein, psychiatrist, Colson Mental Hospital, Martinique.

[21] Winnie Hewitt, Chief Children's Officer, Child Care and Protection Division, Ministry of Housing and Social Welfare, Jamaica.

[22] Reynold C. Dolly, M.D., senior medical officer, Texaco Trinidad, Inc., Pointe-a-Pierre, Trinidad.

[23] Ivy Lewis, Sugar Industry Labour Welfare Board, Jamaica.

[24] K. C. Royes, M.D., psychiatrist, Bellevue Hospital, Jamaica.

[25] Reginald E. K. Philips, Deputy Chief Probation Officer, Jamaica.

[26] Rita Varela, student, Santurce, P.R.

A mental health service experiments in . . .

FAMILY STUDY AND TREATMENT

NATHAN W. ACKERMAN, M.D.
Director, Family Mental Health Clinic, Jewish Family Service, New York

BY TRADITION, the study of human adaptation and associated conditions of health and illness gravitates to one of two extremes; either to the processes of individual personality or to those of society. Accordingly, parallel advances have been made in individual psychology and in the science of society and culture. Paradoxically, however, the study of human adaptation in the area intermediate between the individual and society has thus far suffered a serious neglect.

The family as an intermediate system of behavior offers a unique challenge for study. The long lag in the systematic investigation of the family phenomenon as the unit of experience, of health, and of illness is striking when one recognizes that the family is the critical link between the internal forces of personality and the wider forces of culture. To be sure, the family has been extensively studied as an economic, social, and cultural entity. But the family as a live, biosocial phenomenon with definable psychodynamic properties has not been the theme of scientific research until the last few years.

The reasons for this lag are not altogether clear. One may consider several possible explanations. There is the long tradition of the privacy, the sanctity, the inviolability of the inner life of the family, and the corresponding resistance to intrusion from the outside. This makes the systematic study of the personal, intimate aspects of day-by-day family living difficult. On the other hand, the weakening of the family bond that has resulted from the industrial revolution and from the impact of the protestant ethic and of the competitive pattern of our culture has had the effect of heightening the significance of the individual and of reducing the importance of the family. Thus, the dominant sentiment has become "each man for himself."

Whatever the cause, the scientific examination of the emotional processes of family life has long been delayed. In mental health work over a period of many years, this has had several manifestations: in child psychiatry, a curious trend toward dichotomization of child and family; in psychoanalysis and psychotherapy, an emotional divorce of the adult patient from his family during treatment; in group psychotherapy, a concentration on intrapsychic distortion and neglect of group dynamics.

Looking backwards over some 30 years of child psychiatry, one can detect extraordinary progress in the scientific study of the personality of the child, but no equivalent advance in the scientific examination of the child's family environment. In fact, it is possible to trace the persistent difficulty in achieving satisfactory standards of diagnosis and treatment of psychiatric disorders in children partly to the failure to find ways to diagnose and treat families as families. Guidance programs have been centered on the child as an individual. The child's response to environment has been mainly reduced to an issue of the influence of maternal attitudes, these being appraised as an external agent acting upon the child. The path of study has usually moved from the child at the center to family environment at the periphery. The conflicts, symptoms, and emotional disabilities of the child have not been adequately defined in terms of the child's total personality nor in the frame of his adaptation to his family roles.

As a consequence of this conceptual separation of child personality from family environment, the relations between the child as an individual and the child as part of the family have not been adequately clarified. Only in recent years has the mother-child relationship been understood as a circular process, child affecting mother as well as mother affecting child. Again, only recently has mothering behavior been systematically related to father behavior, and to the psychodynamics of the family as a whole.

During the past 30 years child guidance procedures have crystallized into a tradition of separate diagnosis and separate treatment for child and mother. The direct psychotherapy of the child has been given priority, the treatment of the inappropriate attitudes in the mother being regarded as auxiliary. The evaluation of parent and family has been intuitive, piecemeal, hit and miss. Generally, the child patient has been assigned to the most skilled member of the guidance team, the psychiatrist and the mother, to a social worker. Often the father has been "the forgotten man."

Thus, the child has been treated as all-important, while the family has been regarded as of external and tangential significance. Frequently, the child has been viewed as good, the mother as bad. The child's therapist has taken the side of the child against mother and family. In effect, the therapist has assumed the role of lifesaver, his mission to rescue the exposed, vulnerable child. In this emotional setting, the parent has been visualized as destroyer of the child. Now and then, the child therapist is facetiously called a "mother killer."

The value distortion in this child guidance procedure is clear. It is obviously wrong to pit the child against parents and family. The emotional needs of the parents require the same respect as those of the child. Unless the disturbances of parents and family are examined and understood with the same sympathy and scientific rigor as the emotional life of the child, the child's problem in its larger aspects can never be solved.

Some Clinical Observations

The study and treatment of emotional disorders in children need to be accompanied by a parallel program of study and treatment of the family phenomenon. The importance of this is reinforced by a series of interrelated clinical observations:

1. The emergence of a psychiatric disorder with symptoms in a child patient is regularly preceded by family conflict.

There is a definable relation between the conflicts of the child and the conflicts of the family group. The failure of emotional development in the child is a symptom of failure of the emotional development of the family.

2. If the child is treated and the disorder of his family ignored, the child again falls ill.

3. If the child gets better, other members of the family may either get better or they may get worse.

If the child becomes less anxious, less torn by inner conflicts, and better integrated, the mother and other members of the family may also show a reduction of anxiety and conflict. On the other hand, if the emotional needs of other family members compete with the needs of the child as the primary patient, as the child improves the others may get worse. This is often clearly reflected in the spontaneous remarks of disturbed children in therapeutic sessions. They sometimes exclaim: "Why don't you treat my mother? She's more nervous than I. She needs you more than I do." Or the child may make similar comments with respect to his father or his siblings.

In some cases even when child and mother both improve, the father gets worse.

4. Conflict and anxiety among other family members may block progress in the child's therapy.

This is especially true when the child is the emotional pawn in a conflict between the two parents. If a change in the child's behavior alters the preexisting emotional balance between the two parents, the defensive response of the parents may retard the child's progress.

5. Over a stretch of time, the intervention of professional influence in family affairs, whether by a psychiatrist, social worker, teacher, pediatrician, or nurse, tends to modify the effect of preexisting family relationships and so rebounds to modify the behavior of the child.

6. A disturbed child is often not cured in a single course of psychotherapy regardless of the intensity of treatment.

At a given stage of a child's development, the child may be able successfully to confront certain conflicts and yet at a later stage may not be prepared to face new kinds of life problems. The result may be a new disturbance, regardless of previous therapy. This is more likely to be the case where family disorder persists.

7. When one is able to involve the whole family in a comprehensive program, one is better able to join the goals of treatment and of prevention.

This is especially relevant for the prevention of emotional disorder in the patient's younger siblings.

8. In our country there has been a long tradition of respect for the importance of environmental factors—especially the climate of family relations—as influences on child personality. What is true of child personality is also true of the mechanisms of adult personality, though to a somewhat lesser degree. Even if one takes fully into account the qualitative differences between child and adult personality, the fact remains that the operations of adult personality also depend on the social environment, though this is expressed in a different way.

To be sure, the contrast between child and adult personality is considerable. The child is a growing being; his personality is in the formative stage; there is great fluidity and change; the impact of the environment upon his emotional life is apt to be immediate. The personality of the adult is more organized, more differentiated, more static. Yet these are differences in degree rather than in kind. The adult, as well as the child, is profoundly affected by family environment. We need to know more about the interdependent and interpenetrating effects of the ongoing relations of a person with his family group, at all stages of the life cycle.

Differences at Home

This principle is affirmed in clinical evaluation of psychiatric patients. In the case of child patients, it is unwise to depend exclusively on observations of the child in office examinations. It is extremely helpful to supplement these with observations of the child at home with his family group. Frequently one observes that the same child will behave differently in these different settings, and with different members of his family.

Only recently I had a striking experience of this sort. In a family group containing two daughters, one age 15, the other 10, both children were seriously disturbed. The older daughter was withdrawn, shy, had few friends, and was especially wary of boys. She absorbed all of her energies in study and had a single-tracked ambition to be a doctor. The younger daughter was infantile, restless, overactive, impetuous, and difficult to control. She expressed emotion more with gesture and body movement than through the use of words. She was overaggressive, provocative, intrusive, unsure of herself, and fearful.

In the background there was a chronic marital problem. The father at 62 was an old man; the mother at 36 years was a very young woman. The father was a homebody, who complained bitterly of the mother's neglect of the children, of her restless urge to gad about with her young friends. The mother was an immature, hysterical woman who behaved like a runaway child. The two were sexually maladjusted; the mother had lovers.

In the office interview, what emerged conspicuously from the children's behavior was their sick side. What emerged in a home visit was strikingly different. Elements of strength and health could be observed in these children in their normal habitat with both parents which could not be seen in a formal office interview at all. For example, in the home visit, the girls showed more security and confidence. Their behavior was better balanced, more appropriate, freer, more spontaneous, and at the same time revealed more appreciation of the individual differences between them. They revealed more expressively their individual interests and aspirations. In the home atmosphere, they were responding to the more familiar evidences of the parents' joint concern for their welfare.

Similarly, one can learn more about the total behavior of an emotionally troubled adult by interviewing him with his family or visiting with him in his own home in addition to seeing him alone in the clinic. What one can observe exclusively in the process of psychiatric examination in a clinician's office is often not enough and sometimes misleading. For this reason, for many years, I have made it a practice to parallel the psychiatric diagnosis of the patient with a family diagnosis.[1]

The family approach to mental health problems is an experiment true to nature. It enables the therapist to examine within the dynamics of the family unit how mental health is promoted, how breakdown may be prevented, how illness may be cured. He can explore those familial processes that are related to breakdown and also other familial processes that are related to healing, to spontaneous cure. He can begin to see how the natural events of family life either heal or fail to heal disturbance in its individual members.

This approach is now being used with emotionally disturbed children at the Family Mental Health Clinic in New York. At this clinic, under the auspices of the Jewish Family Service, diagnosis and treatment are tied into a broad research program of the study of family processes as they relate to mental illness. Here the study of family process had led to the capturing on educational film the true-to-life behavior of psychiatric patients adapting to their natural day-by-day environment, the family.

Specifically, in these studies we are trying to learn:

1. How to describe the emotional and social life of the family group as a basis for diagnosing the psychosocial functioning and mental health potential of the family unit.

2. How to compare and contrast family groups, thus making a way for a family typology with respect to mental health functioning.

3. How to correlate family dynamics and individual dynamics with respect to mental health.

4. How to develop a psychotherapy of the family group.

5. How to find ways to join the methods of psychotherapy with those of social treatment and family life education to apply them in an integrated program for the promotion of mental health and the prevention of mental illness.

The complex nature of this undertaking may raise the question: "Can it be done?" The answer is that it is being done. We have been working on all phases of this program at the Family Mental Health Clinic with a conviction of real progress. While indeed complex and difficult, it is not any more so than attacking the problems of mental health through isolated individuals. In fact it may in the end prove easier because the therapist's intervention comes at a more natural time—when the family members are interacting with one another. It does not have the effect of distorting emotional and mental experience by isolating the patient from his environment.

In fact, when an individual patient is treated away from his family he brings the images of his interactional experience with his family group into his therapeutic sessions anyway. The therapist is forced to deal with these images of other family members, but does so in symbolic form. The comprehensive attack on the problem provided by the family approach enables the therapist to use actual face-to-face contacts with members of the family rather than to rely only on vague symbolic relations with them.

Foci of Study

In studying a family, we pay particular attention to the following:

1. The organization and balance of family functions.

2. The process by which roles within the family become complementary.

3. The patterns of conflict and control of conflict. This includes consideration of trends toward scapegoating of an individual member and delegation of another member to fulfill the role of family healer.

4. The capacity for change and growth; that is, for the achievement of new levels of family role complementarity. This capacity determines the potential levels of maturation of the family as family, as well as the emotional growth of its members.

5. The representations of family identity and the corresponding value orientations.

6. The degree of correlation between the health of the family as a whole and the health of its individual members.

In order to carry out its research goals, the clinic limits the caseload to some 50 families. The professional staff is composed of four groups: psychiatrists, social workers, social scientists, and psychologists. Of these, the psychiatrists and social workers carry the clinical responsibilities of evaluating and treating whole families. Within this larger group, a smaller research team of a multi-discipline type carries on a series of specific interrelated investigations in family dynamics as this pertains to emotional illness and health.

In the carrying out of health services to these families, we do not follow the traditional pattern of clinical assignments for psychiatrists and social workers. Assuming prior training in the methods of family diagnosis and treatment, both members of the psychiatric and social casework profession undertake therapeutic duties. As a matter of principle, when the family has a psychotic member, such a case is generally assigned to a psychiatrist. Otherwise, where the causative factors are mainly social, we try to fit the needs of a given family to the talents of a particular professional staff member rather than obeying any stereotyped standard for the specialized use of the professional categories.

The motion-picture studies on family interview process are made in the first instance for purposes of specific investigations, but also serve as a unique instrument for training members of the behavioral sciences in the principles of family diagnosis and therapy. The families who are thus filmed sign a release which permits us to make full professional use of these films, but do not permit us to exhibit these films to lay audiences. Not only are the families fully aware of being filmed during interview, but they are also informed that the entire staff of the clinic is observing the interview from behind a one-way-vision window. Directly following the filmed interview, there is a clinical seminar in which the emotional events of the interview are evaluated.

In our experience, families understand and appreciate the value of the filming process, both for purposes of study and for reaching greater clarity and precision in diagnostic judgment and in the psychotherapy of the whole family. Generally speaking, beyond the first few minutes, just as soon as the emotional interchange is deeply felt by the family members, they lose all self-consciousness and are not in any sense "on their good behavior." The prevailing patterns of emotional interaction among the family members and between them and the therapist can thus be viewed as characteristic of the given family and reliable for diagnosis and treatment.

I am often asked whether the family approach competes with the individual approach to therapy. The answer is: "No. It is complementary." The individual forms of psychotherapy are useful in attacking entrenched forms of psychiatric disorder with organized symptoms such as phobias and obsessions. Since intervention in family interactions can affect the ongoing relations of individual and family group, it influences the course of the illness and the patient's response to individual therapy. These ongoing relations in the final analysis govern the balance of forces that predestine relapse or cure.

Complementary Techniques

Effective intervention in family interactions requires the appropriate focusing of therapeutic influence to certain pathogenic foci, such as destructive attitudes or unrealistic expectations, within the family group. Regardless of the particular time at which the clinician intervenes, he can trace within the family processes those clusters of pathogenic conflict from the past which continue to influence the disturbance of the primary patient.

The foci of disturbance within the family group that originally contributed to one member's psychiatric illness continue to assert themselves in the here-and-now aspect of family interaction, though they may in time change their mode of expression, since the emotional organization of family life changes over a period of time. Therefore, intervention in family interaction requires appropriate timing and staging. It is, however, possible to design a parallel program of family psychotherapy and individual psychotherapy for those family members whose psychiatric condition may require it.

No technique of psychotherapy which is presently known is total in its effect. Each exerts a partial and selective influence on some components of the disturbance, but not on all. Psychoanalytic therapy exerts a selective influence on the depth phenomena of personality. Group psychotherapy of the usual type exerts a selective influence on the character, attitudes, and preferred social modes of the patient, in other words, on the role adaptation of the personality. Family psychotherapy in turn has a distinctive quality. It holds the unique potential of selectively influencing and eliminating specific components of disturbance in family interaction.

The family approach to psychotherapy holds far-reaching implications for a changing orientation to mental health services, especially for the development of new health programs for child and family. The recognition of these principles led to the formation of the Family Institute in May 1960 as a nonprofit national organization representative of psychiatry, psychology, medicine, social work, and related professions, with the twin goals of preventing family disorder and supporting the development of effective health in family living. The institute, with headquarters in New York, will carry out the following functions:

1. Develop facilities for diagnosing and treating emotional disturbance through families; that is, evaluating and treating conflicts and symptomatic disabilities in individuals through therapeutic intervention in the emotional life of the whole family.
2. Develop specific research studies relating to the processes of breakdown and illness within the family as a whole and to work toward the restoration of family mental health.
3. Train psychiatrists, psychologists, physicians, and social workers in the principles of family diagnosis and family treatment.
4. Promote education in the principles of sound family living.
5. Prepare, publish, and distribute educational materials for members of the various professions working with disturbed families. This includes studies in film of the methods of family treatment.

The significance of the family approach to mental health problems derives from a number of considerations. Such an approach provides us with the possibility of specifying and amplifying our present incomplete knowledge of the interconnections between individual dynamics, family dynamics, role adaptation, and mental health. It can trace the circular pathways of emotional interchange between individual and family, thus throwing light on the role of family life in the precipitation of illness, in influencing its course, in the response to therapy, and in the probability of recovery or relapse. It can illuminate the phenomenon of secondary emotional gain in illness. It can provide a laboratory for the further exploration of the unsolved problems of homeostasis of behavior and the related question of the balance of emotional forces between illness and health. It may add new knowledge to the question of the relations between identity, value orientation, and mental health.

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[1] Ackerman, Nathan W.: The psychodynamics of family life. Basic Books, New York, 1958.

GROUP EDUCATION FOR PARENTS OF THE HANDICAPPED

ALINE B. AUERBACH

Director, Department of Parent Group Education
Child Study Association of America

THROUGHOUT the country there is a growing interest in group programs for parents of handicapped children, an interest which is not surprising since group programs for parents of well children have become part of many American communities. This interest is being picked up by the increasing number of parents' organizations that have been formed around disabilities to acquaint the public with the nature of the handicap, to raise funds for research, and to push for more and better services for their children. Quite naturally the major attention of these organizations has from their inception been concentrated on the children.

But individual parents have been reaching out for more—a kind of knowledge and help that they have hardly defined for themselves. Their desire for help has been revealed in informal discussions around the edges of business meetings, sometimes even taking the center of the stage and interfering with the main purpose of the meeting.

Thus many agencies serving the handicapped have come to see the need for two different types of parents' programs—one with focus on community action to improve services for all children having the specific handicap with which they were concerned, and the other with focus on helping the parents in their daily living with their children. Where separate programs could not be set up, parents' meetings have been more effective when the two goals have been identified and handled separately.

Agencies providing services for handicapped children have often held informational meetings for parents in the form of lectures by the professional staff, describing the disability and the therapeutic, educational, and other services available. While these meetings have been useful, the persons programing them have often felt that more should be offered, through casework services or another kind of group program or both, to meet the needs of the parents as they themselves see them.

However, in attempting to develop more meaningful group programs, agencies have often been limited by the lack of group leaders. Even well-trained social workers and psychologists often feel unprepared to conduct group programs of this nature. Therefore, professional persons of various types have been turning to the Child Study Association of America for preparation for this work.

Parent Group Education

Within the past 10 years the association has given training in parent group education to selected social workers, psychologists, educators from various settings, and public health and hospital nurses. This training has concentrated on the use of group discussion geared to the needs of the parents in the group and developed from their expressed concerns in a flexible procedure, rather than to a predetermined curriculum.

In parent group education the goal of the leader is to help group members explore all aspects of the situation in which they find themselves with their children, to gain greater knowledge and understanding of their children's physical and emotional development, of their own roles as parents, and of the complexity of parent-child relations. They do this through the exchange of ideas and experiences within the group interplay, looking at both facts and feelings—theirs and their children's. Sharing their reactions with others under skillful leadership seems to free the parents to move on to new attitudes and new behavior, or to have greater confidence in what they are already doing.

The goals and techniques of group education are different from those of group therapy. The group education leader does not focus on the pathology of the members, or probe into the unconscious. Although he must take into account the unconscious factors that influence behavior, he deliberately directs group thinking toward aspects of ego functioning, in order to develop ego strengths.

Some Questions

In the early programs of training leaders for parent group education, the focus was on parents of normal children. As the interest mounted in establishing programs for parents of the handicapped the association was asked to set up a special training program for social workers who would be working with families of children with disabilities.

Implied in this request were a number of important issues:

- Is the method of group education developed for parents of normal children applicable to groups of parents of children with such different problems?
- How similar and how different are the concerns of parents of chronically ill or disabled children from those of parents of well children who present merely the normal range of developmental problems as they grow up?
- Can group education be expected to ease the extraordinary burdens on parents of the handicapped and help them to handle their lives and those of all their children, including the nonhandicapped, with greater ease and satisfaction for all?
- Do adaptations in techniques have to be made in working with parents of the handicapped to achieve the basic goals of group education for all parents, and, if so, what is their nature?

The association had already recognized that these questions needed further exploration in practice as well as in theory. It had, therefore, set up experimental groups, under the sponsorship of various health and rehabilitation agencies, for parents of children with muscular dystrophy, cerebral palsy, mental retardation, and two congenital blood diseases. The groups were conducted by association staff members who had familiarized themselves with the nature of these specific disabilities and the special problems they presented for parents as well as children. A social worker from the cooperating agency usually participated as a resource person. The association also had had experience in adapting the basic approaches of parent group education in programs to train public health and maternity nurses to lead groups of expectant parents.[1]

Encouraged by these experiences, the association, with a foundation grant, set up a demonstration program to train social workers in parent group education for parents of handicapped children. The hope was that the experience of the social workers in conducting parent discussion groups in their own agencies would throw more light on the foregoing questions. The association also looked to the project to explore some questions regarding the recruitment and readiness of parents for this type of experience, and the effect on the groups, of their makeup, in relation to degree of homogeneity in the parents' backgrounds, and in the prognosis and severity of their children's conditions.

A New Project

The project was initiated with a selected group of social workers from the staffs of hospital social service departments and health and rehabilitation agencies in New York City, and from the New York City Health Department. These agencies were interested in developing group educational services for parents and had experienced social workers who were familiar with the disability of the children with whose parents they would be working.

The program included 15 weekly sessions devoted to a review of the principles of child growth and development and the many distortions created by various disabilities; discussion of the parental concerns common to all parents as they are colored by the nature, prognosis, and special meaning to parents of their children's handicaps; and presentation of the principles, goals, and techniques of parent group education as applied to the needs of parents of handicapped children. These sessions, conducted by guest experts from the fields of medicine and rehabilitation, psychiatry, psychology, education, sociology, and cultural anthropology have been supplemented by seminars led by association staff members who also supervised the participants as they conducted parent groups in their own agencies, in health and rehabilitation organizations or in special clinics, recreation and workshop centers, hospitals, and public schools. Each parent group was concerned with a specific disability—orthopedic handicaps, cerebral palsy, mental retardation, or cleft palate—except for two groups of parents whose children's disabilities were not all the same.

What Emerges?

What takes place in such groups? Since the subject matter is not preplanned but is developed from the interests of the members, there can be no general answer. Parent group education, like casework, focuses on the parents and their concerns, meeting them "where they are." So the discussion may start at almost any point.

Often the early meetings of a series are taken up with practical problems of routine care as compounded by the child's disability. Parents of young children who are mentally retarded or cerebral palsied or both bring up their struggles with the whole range of developmental tasks they are trying to help their children to learn—feeding, toileting, dressing and undressing, climbing stairs. Parents of severely orthopedically handicapped teenagers may talk about the constant chore of getting their young people to school, a recreation center, or just outside the house.

Everyday problems continue to appear in many forms throughout the series of meetings, and in these discussions the parents gain a great deal from the experiences of others. Even though the degree to which their children are disabled may vary enormously, the ingenious procedures some parents have worked out often open up new ideas relevant to many different situations, which the parents often adapt to the needs of their own children. Sometimes a parent has tried a new way of bathing a severely crippled child, for example, or a different approach to getting a cerebral-palsied child to feed himself, or a rearrangement of the furniture to provide greater play space.

While the parents discuss these ideas, they are constantly working on one of the baffling aspects of their problems, that of evaluating their child's particular timetable of growth and development. For many handicapped children, there is no set guide. Each parent has to find out what stage his child has reached, in relation not to age, but to the limitations imposed by his disability as well as to his capacities.

With the leader's encouragement, parents are often able to bring out the basic questions that lie behind these practical discussions, revealing a few central themes variously expressed. The common question, "How much can my child really do?" may be a front for many others: What is the true extent of his disability? What does this mean for me? How much should I do for him and how can I best help him learn to do things for himself? What is my real role as a parent, what kind of a parent do I want to be, and can I really carry out what I think I should do? Will he be able to take care of himself later on? What does the future really hold? Will I ever be free of this endless burden?

Whatever the parents begin to talk about may uncork a flood of feelings. Sometimes these feelings burst through in first or second meetings, sometimes they are held back until late in the series, when the parents feel more at ease. Parents often reveal in groups what they say they find it more difficult to reveal in one-to-one talks with doctors, psychologists, and social workers—especially their confusion about what they have been told regarding their child's disability. Often they say that they have not been told enough and that they have not been met with sympathy and understanding. The frequency of these comments even though the medical, nursing, and social service personnel are known to have been competent, thoughtful, and friendly suggests the extent of these parents' need for support and perhaps also their difficulty in absorbing the reality of what they face.

Many parents gradually come to see the extent of this need as well as the unreality of their expectations. They discuss what may be pushing them to continue to "shop around"—the wish for a magic cure or a new diagnosis since the reality seems so unbearable. Yet at the same time they recognize that they must reach out for all the services available to the child and press for more if needed.

Other feelings emerge in different ways from group to group. There seems to be a strong, deep undercurrent of anger, frustration, and guilt that needs to find an outlet and breaks through whenever it can. Within the supportive atmosphere of the group, parents begin to talk about their anger and frustration, sometimes directed at the child himself but more often at medical services, random happenings or just fate. When they recognize that these reactions are shared by others and are accepted as natural by the leader and the group, they come to feel less guilty about them and are better able to look at them more realistically.

A similar process occurs when parents bring out their feelings of deep disappointment in their child, of having a constant, endless burden and, sometimes, of being drained of all individuality. They say again and again that they feel personally responsible for the disability, although rarely is there any justification for their self-reproach.

These complex feelings appear to be almost universal in our culture. They seem to flow from a basic part of our emotional lives, from our expectations and dreams, our hopes and fears regarding our children. The degree and expressions of such feelings, however, vary considerably, according to the parents' individual temperaments, the nature and severity of the child's disability, its causes and prognosis, and the special significance it may have for the parents.

Yet whatever these feelings may be, looking at them honestly with others who share them to some degree at least, seems to open the way for parents to accept themselves a little better and to be able to test the feelings against reality. This testing in turn seems to free them to gain a better understanding of all their family members' needs and of their own inner resources.

Some people, of course, are so caught up in their emotions that they cannot make use of group educational experiences of this kind. Therefore, some of the agencies in this project opened the groups only to parents who seemed to their social service personnel likely to profit from the experience. Others invited all parents on a general list of patient contacts to attend. Still others invited any parent in the general public who had a child with the particular disability. Whatever the method of group recruitment, the leaders were alert for parents who either showed no movement during the series or seemed disturbed by the discussions in ways the group could not be expected to resolve, and referred them to casework or psychiatric treatment services. However, some parents who presented a discouraging picture, during earlier sessions, eventually showed surprising shifts of attitude, often first moving out of their own preoccupations to help other parents in the group and then applying a new approach to their own problems.

Comparisons

How different are these group sessions from sessions with parents of well children? The association's staff believes that there is a basic similarity in the nature of the experiences for all parents, but that there is a marked difference in the intensity of the feelings expressed and in the quality and degree of parental concerns.

The range of questions that come from parents of children with handicaps are actually very similar to those raised in groups of parents of normal children. For example, parents of well children are also concerned about how much their children can do, how they can best help them to develop their capacities without pushing them too hard, on the one hand, or not giving them enough stimulation and encouragement, on the other. They too, often voice the disappointments they feel as they compare their children with the dream children they had looked forward to.

The difference lies in the reality behind the words, in all the complicating factors connected with the disability that so often leave parents of the handicapped child struggling to find their way alone day by day in dealing with their child and in coping with their own emotional reactions. The burdens of these parents are infinitely greater and the reality is much more threatening, both now and for the future. The practical choices open to them in such matters as schooling, family mobility, and social life for the children and for themselves are far more limited. The satisfactions of parenthood for them are less apparent, though they can find satisfactions if they can move past their difficulties to recognize them. For them the experience of parenthood is a constant problem, in which the concerns of other parents are greatly magnified.

And so the feelings, when they come, pour out in these meetings with greater intensity. This is true not only with parents who have recently been confronted with the problem of having a handicapped child, but also with parents who have lived with the problem for some years. In the case of the latter, one can only speculate as to why the intensity of feeling has continued. Perhaps these parents have never fully faced the shock of knowing their child is handicapped and so have not thoroughly lived through the crisis that comes with this knowledge. Perhaps, because of the constant demands on them, their lives seem to be one crisis after another. Perhaps they have never before had the chance to express what they feel.

Leadership Problems

Parents' feelings are an important part of any group educational experience, but the intensity of feelings of parents of disabled children present some leadership problems which are not unique to these groups but appear in exaggerated form. Once the dam of pent-up feelings gives way, it is often hard to stop the flow. How long should the leader allow the talk to continue in this vein? How much do the parents have to "get off their chests" before they can begin to look at the meaning of these feelings and learn to handle them better? When is it wise to help them out of the morass of emotions, so that they will not get stuck and only feed each other's self-pity? How can one do this without cutting them off before their feelings are fully relieved?

The answers to these questions depend on the leader's sensitivity to the reactions of the individuals in the group and on his judgment of the impact on them of the group interplay. He also makes use of his social casework knowledge of how and when to further a client's movement toward new insight.

Some group leaders with a background of social casework became uneasy when the parents spilled over their strong and often hostile feelings. Although they were prepared to handle such outpourings in a casework interview, they were afraid they might not be able to handle them in a group. As they gained more experience and worked on the problem with their child study consultants, they found that these outpourings, like any other material presented by the parents, could be discussed within the group and used to good advantage, even though difficult moments might occur. They discovered too that the situation is often eased by the spontaneous, self-regulating dynamics of the group; that the members themselves pull away when the impact of the discussion is too heavy and often support and reassure a parent who may be revealing too much. They found too that the leader can step in when necessary, to put the parent's revelation into a more impersonal framework, by universalizing it with a sympathetic comment or directing the discussion into some other, more general, area.

These parent groups have exhibited considerable variation in mood. In some, the mood apparently stems from the chance combination of personalities, but, in others it seems to be related to the nature and severity of the children's disability. For example, the meetings of a group of parents of severely cerebral-palsied and mentally retarded young adults were noticeably depressed in tone. These parents had lived with their children's problem for 20 years or more and saw no hope of improvement.

The leader of a group like this faces the danger of becoming caught up in similar feelings. He can, however, guard against this and try to help the parents talk not only about their heartaches and problems but also about what they have accomplished for their sons and daughters and for themselves.

Helping parents examine their successes as well as their failures is basic in all parent group education. In groups where the parents face especially tragic situations the attitudes reflected in the group tone are often fixed and hard to shift. The group works slowly as though in low gear. Yet a skillful leader who makes full use of group support and sympathetically encourages the parents to look at different facets of their experiences, can help the parents achieve another perspective and, sometimes, a little break in mood. Such groups, however, might be encouraged to meet for more sessions, and their members should perhaps be offered periodic casework contacts.

Mixed Groups

Other variations in group movement are found in groups composed of parents of children with different disabilities or children who have a similar disability but a wide range of impairment. The basis for these parents coming together is that they share the common experience of having a handicapped child, but differences in the nature or degree of the child's handicap may set each family off in a separate category. Even in groups built around a common label, such as mental retardation or orthopedic handicaps, parents often become preoccupied with the fact that their child is much more (or less) disabled than the children of the other group members. Whether they are deeply envious of the other parents or relieved at their own favorable situation, their awareness of the differences makes it hard for them to see and share their common problems and so to learn from one another. These groups too work at a slower pace and require unusually sensitive leadership.

Experience so far suggests that parent groups function more effectively if they focus on children whose disabilities are fairly similar and who are within a defined age range. However, in groups of parents of the handicapped, the age range of the children can be wider than in groups of parents of well children, who follow a developmental timetable much more closely. More experimentation is needed before one can begin to assess adequately the advantages and disadvantages of homogeneity and of problems in these parent groups.

Leadership Techniques

All parent groups require a flexible and creative use of group leadership techniques to meet the needs of the particular parents in the group. The charge of parent group education under any circumstances is to use these skills to further the parents' total understanding of their children, of themselves as parents, of parent-child relations, and of the interplay between the family members. With parents of handicapped children there is the added factor of the handicap and its effect on all the family, as well as on the disabled child. But the approach to these parents involves the same goals and techniques as to other parent groups, consciously applied to their special needs.

Social workers are especially well equipped for leadership of these parent groups as they bring to the task a rich background of knowledge and experience with individuals and families and a keen understanding of the dynamics of behavior. Those who have participated in the training projects have also brought a thorough knowledge of the specific disabilities involved and their implications for children, though they have not always seen the children clearly against the background of normal child development. Sometimes out of eagerness to see that the children are helped to develop as far as possible, they have overlooked their emotional needs as children. Some have found it difficult to maintain a balance of empathy and have tended to identify either with the parents or with the children.

At first some of the social workers were preoccupied with and somewhat fearful of the group approach. As a result, at times they failed to recognize the way in which they were already carrying out the objectives of the program in basing their leadership on social work concepts, adapted to the group and directed along broadly educational lines. In time, however, they came to realize this and their leadership skills developed with a new spurt.

Several social workers have reported that the program has sharpened their casework skills by sensitizing them to listening more thoughtfully for the deeper concerns of parents of the handicapped. They have also said that they now recognize more clearly that these parents are able, within a guided group experience, to develop strengths which they can consciously use to help their handicapped children.

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[1] Auerbach, Aline B.: Group participation in expectant-parent classes. *Children*, May-June 1958.

. . . We'd better face it. We will either help our young people to find great dreams to work and live for, or they will give us nightmares to live with. Man must have adequate opportunities to create according to a dream. Denied them, he will destroy out of the dark, blind impulses of the nightmare of frustration.

Rev. Donald Harrington in a sermon at the Community Church, New York.

A large public agency involves all levels of personnel in . . .

A DEVELOPMENT PROGRAM FOR CHILD WELFARE STAFF

CAROL H. MEYER

Director of Training, Bureau of Child Welfare
Department of Welfare, City of New York

FOR THE PAST 3 years the Bureau of Child Welfare of the New York City welfare department has been using Federal child welfare services funds for a training consultant to devise and administer a demonstration staff development program growing out of the practice and staff needs of the Bureau of Child Welfare. In this time we have gained sufficient experience to reflect upon the values and hazards of an inservice training program in a large urban public child welfare agency. While the New York City agency has special problems because of the size of its client population and of the staff necessary to carry out its multiple functions, the introduction and conduct of the staff development program encompasses principles of such a generic nature in social work practice that examination of its experience might well interest agencies in other communities. We have gained some successes and have skirted some failures, but the hunger for staff development and the observance of a basic social work process in devising and carrying out the program seem to have won out over the obstacles.

The Bureau of Child Welfare serves over 12,000 families and is responsible in a variety of ways for about 24,250 children in foster care and in day care. It has a total staff of 1,417 persons, of whom 548 are social service staff; 588 administrative, clerical, and other staff, including educational consultants in day care, institutional aids, and a variety of auxiliary personnel; and 281 children's counselors in 3 temporary care shelters. The Bureau operates through nine separate divisions, each carrying out a separate part of its extensive functions: study and exploration, prevention and placements; administration and supervision of child placements made by the Bureau through voluntary agencies and institutions; direct foster home care, adoption, temporary care, and day care of children; and services to unmarried mothers. Thus the wide variety of services presents a tremendous challenge to efforts at staff development.

We are working at this time only with the social service staff, but we anticipate that eventually the supportive staff will also become involved in the program. The social service staff includes 397 social investigators or field workers, 75 unit supervisors, 25 case supervisors, 11 senior supervisors, 9 division directors, and 5 administrative staff. Of the total, 57 have completed their professional social work education and another 35 have completed 1 year of professional training. Through the benefit of Federal funds for child welfare services, we are able to send from 20 to 30 staff members to schools of social work each year, but even without taking into consideration the inevitable loss of some of these trained staff, we could not anticipate a fully trained staff for the Bureau of Child Welfare in less than 20 years. Realistically speaking, we must expect that for many years most of our social work staff, particularly on the practitioner level, will not have professional education.

There is an annual turnover rate of about 38 percent among the social investigators, while the supervisory and administrative staff remains somewhat stable. This means that the bureau must hire about 150 social investigators a year, thus requiring a large amount of the staff development effort to be spent in the orientation and training of newly hired people. One may ask where else the training effort could more appropriately be placed? This question, the way in which we have defined staff development, and the reasons for our increasing attention to the learning needs of supervisory groups, will be dealt with as we describe the purposes and methods of the staff development program itself.

Staff development in the Bureau of Child Welfare has been defined as the development of the practices of all staff—social service, institutional, and clerical—that directly or indirectly affect services to families and children. Thus, staff development is a term applicable to the experienced and the newly hired, the professionally trained and the untrained, since it does not necessarily imply "training" for a job, but rather, refinement or deepening of knowledge and skills in whatever level of staff such educational need exists. *Inservice training* has been defined more narrowly as direct teaching to new staff of the job to be done within the bureau's structure. Since within the closed civil service promotional system only the first level of social work staff, social investigators, are brought into the bureau from outside, inservice training has been confined to newly hired social investigators.

According to these definitions, the larger purposes of staff development are achieved only as supervisory staff and administrators examine and gradually improve their practice. Inservice training, while essential to the operations of the bureau, is decidedly more limited in its aims, since it affects a portion of staff composed of persons whom we are never sure will remain with the bureau, and whose educational needs for a period of time are restricted to learning the rudiments of the social investigator's job.

According to the major premise of the bureau's staff development program, its lasting effectiveness will stem from the continuous involvement of the *total* staff in the learning and teaching of the social work attitudes, knowledge, methods, and skills of sound child welfare practice. Thus, it has been our task to conceive of a program that would be sufficiently flexible to accommodate itself to practitioners in all stages of experience and to three levels of supervisors representing a wide range of educational preparedness. The content of the program has had to be generic enough to serve the practice needs of the total bureau, and specific enough to meet the interests of each of the nine administrative units. The methods used in carrying out the program have had to be effective for all elements of staff without interfering with the operations of the bureau, holding out something new without at the same time threatening to eliminate the familiar.

The Process

The process through which the program has been developed contains similarities to the social work process itself as this is characterized by certain basic concepts and philosophical tenets and the use of the scientific method.

First, the learning needs of the staff had to be studied and assessed in the light of the purposes and practices of the agency and the stage of development the staff had reached. Second, the obstacles to staff development inherent in the agency and the staff had to be understood or "diagnosed" so that our program could at the least adapt to these resistive areas and pursue appropriate and reasonable goals. Third, the resources within the agency and the potentialities within the staff had to be evaluated in relation to what the program might offer.

Finally, on the basis of these assessments, we determined to proceed with a variety of methods, each geared to a particular level of staff and its special area of responsibility. In keeping with our premise that the staff itself had to be directly involved in the planning, carrying out, and evaluation of the program, our chief efforts have been directed to all supervisory staff who have continuing administrative and teaching responsibilities and upon whom rests the burden of the bureau's practice.

Whereas adherence to this underlying premise of participation has meant that staff development began slowly, remained on a fairly low educational level for a time, and required an inordinate amount of planning, the results have indicated that this gradual process was a sound way of introducing the program. We have not relied upon lectures from outside the agency, despite the wealth of professional talent and resources in New York City, nor have we introduced formal teaching within the agency. Instead we have depended upon agency workshops that have been geared entirely to the staff's readiness to review what they knew and to absorb new material. We did not model an inservice training program upon already tested syllabuses, but rather devised a limited central training plan and placed the burden of teaching upon the supervisors themselves. We have not encouraged staff to attend institutes offered in the community unless they can integrate what they have gained back into their agency practice.

We have found that the bureau has its own resources for staff development as does every public agency—staff that can be encouraged to teach, and thus learn—and professional and educational purposes that derive from the work of the agency itself. However, we have proceeded on the theory that for these resources to prove useful to the staff, agency, and community, there must be some administrative responsibility for keeping staff development in continuous touch with social work developments occurring outside of the agency, so that the content of the agency's program does not become sterile but stays continually enriched.

We have demonstrated that these methods of staff development can be integrated into the administrative and supervisory structure of an agency and that it can be flexible enough to adjust to agency function and operation, and staff readiness and interests.

Finally, and probably most important, we are finding that such a program carries its own insurance for continuity. If a staff development program derives merely from experts within or outside of the agency, there is no guarantee that when these experts are removed there will continue to be a staff development program. On the other hand, where a large proportion of the staff itself is participating in the staff development process, with administrative leadership, this will become as much a part of the staff's normal functioning as the direct practice in which they are continuously involved.

So far the groups to which the bureau's staff development program have been directed have been: newly hired social investigators, unit supervisors, case supervisors, and senior supervisors. In another year we will be experimenting in reaching the staff through other kinds of groupings. In the first years of the program, we followed the groupings of the civil service classification system, as this arrangement was clearly acceptable to the staff.

Because of the high turnover in social investigators, we must train an average of 35 to 40 new staff every 3 months in order to keep the bureau fully staffed and caseloads covered. If this turnover decreases with increased staff interest in the work and anticipated changes in working conditions and salaries, we intend to hire staff at longer intervals—hopefully as long as 6 months, so that we can sustain a 6-month training period for all newly hired social investigators.

Induction of New Workers

These workers are all college graduates. Some have had social work experience, but usually none have had even one class in a school of social work.

Orientation takes place in 1 day, during which we describe briefly the work of the Bureau of Child Welfare, its place in the Department of Welfare, and its personnel practices, and only those aspects of the job that are essential for the workers to get started. We rely heavily upon the groups' questions to let us know about the members' knowledge, experience, and sophistication.

After the orientation session the members are assigned to training units in different divisions of the bureau to begin their training and work. We have restricted the orientation period to 1 day out of the conviction that newly hired workers are overwhelmed when they arrive and cannot absorb nor retain any material that is not directly related to their immediate situation. In addition, we believe that new staff learns best on the job, and that waiting during an extended orientation period tends only to increase tension and anxiety.

In addition to being taught on the job in their training units, the new workers meet together in central training sessions for 2-hour training sessions once a week for about 3 months, although we would extend this if the 6-month training period were to become a reality. The educational goals of these central training sessions are limited, as we believe that integrated learning in social work takes place through supervision of practice. An operating agency of this size, with a wide range of quality in supervision and a great deal of work pressure, cannot and should not teach new staff theories that cannot be assured of support by the supervisors in day-to-day practice. When training sessions heavily weighted in theory are directed only to new staff, supervisors fail to become involved in the same learning as their investigators. The results of "overteaching" new staff is more often threatening to the supervisors than enlightening to the new workers.

We attempt to achieve three specific purposes in the weekly training sessions:

1. Provide an opportunity for new staff from all divisions to meet together to become identified as bureau staff and at the same time to become

exposed to the various functions of the bureau.

2. Teach that general content of the basic social study which relates to every bureau case. This approach serves to introduce or reaffirm the points being made in supervision in regard to specific cases.

3. Develop positive attitudes about any part of social work theory and practice to which new staff is exposed. We have recognized that it will never be possible to include all the social work substance that new social investigators need to learn, nor to time sessions so that they will meet the immediate practice needs of staff. Also, in keeping the central training sessions on a general and conceptual level, we recognize that the use to which social investigators put their new knowledge will not be evident right away. Our chief purpose will have been met if we succeed in developing in new staff a general attitude of readiness to learn new things and new ways of working with people.

Training Units

In accordance with the staff development program's basic premise that training opportunities should grow out of the bureau staff and practice, the program's major emphasis is placed upon on-the-job training in the training units established for newly hired social investigators. These units have served multiple training and administrative purposes.

While there have been great administrative difficulties in working out the training unit plan, the advantages have decidedly overbalanced the disadvantages.

As for positive results:

- The training unit plan has made it possible to greatly reduce the numbers of supervisors who are involved with new staff. This has resulted in an extraordinary saving of administrative and clerical time in planning the new workers' training program. Only 10 to 15 supervisors rather than 50, have to be consulted.
- The plan has made it possible to select for the program only those supervisors who are well qualified to teach, who favor an educationally focused supervisory approach, who are motivated to be training supervisors, and who want to give attention to the special learning needs of newly hired workers.
- Under the training unit plan supervisors can teach general basic material to several workers at once instead of having to repeat this material to each new worker individually as he enters a regular unit.
- The plan has made it possible in most instances to select the cases for assignment to new workers on the basis of their usefulness in providing opportunities for the development of learning from simple to complex tasks.

Thus the training unit system has not only singled out the educational focus for newly hired staff, but it has also relieved the nontraining supervisors from the continual pressures of teaching new staff.

The problems presented by this training unit plan have stemmed chiefly from staff shortages. Obviously the carving out of "protected" units in the operating divisions of the bureau means that the workers in the remaining units have to absorb the pressures of coverage. Sometimes these pressures become so great that they are of necessity moved back to the training units, and while the training unit supervisors have responded to this by quickening their pace with the new social investigators and assigning larger caseloads when necessary to provide coverage, the gradual procedure of the educational process naturally has been affected. This might be regarded as a severe hazard to on-the-job training, unless one accepts the fact that even work pressures are part of the reality for which new staff must be trained.

There have been other administrative problems in regard to this new program as well as some natural resistance among staff, but the greater our experience with training units, the fewer difficulties appear. The bureau's current policy is that newly hired social investigators must be assigned to training units with selected training supervisors. Thus after a year of demonstration, the units have become an integrated part of the bureau.

Training Unit Supervisors

Training units have led naturally to the opportunity for us to work rather intensively with the training unit supervisors. From the beginning of the training unit plan, its administrative details were worked out with these supervisors, and the content and method of educationally geared supervision were developed continually through ongoing supervisory workshops. These supervisors not only have participated actively in all aspects of their new teaching role in the Bureau, they also have carried a major part of the development and continuing evaluation of the central training sessions—determining the nature of the content of these sessions as differentiated from the content of their sessions with the new workers in their units. They have, in fact, demonstrated the validity of our basic premise that staff development appropriately involves staff participation in every aspect of the program.

Since the training unit supervisors carry the chief responsibility for direct teaching of new staff, we have made many efforts to enrich their learning as well as that of the new workers. In the course of our exploration of learning needs in the bureau, we found among social investigators, a serious deficiency in their understanding of human behavior. Since we could not hope to send our 397 social investigators to schools of social work, and moreover, believed that learning at their level should take place on the job through their supervisors, we arranged for a school of social work to provide a noncredit extension course in human growth and behavior for the training unit supervisors. The course was also open to supervisors who would be supervising the workers in the posttraining unit phase of their early experience at the bureau—a beginning effort to follow through and continue the training atmosphere for newly hired staff as they move on to increased responsibility.

The purpose of the course, which is conducted jointly by a psychiatrist and a teacher of social work, is to present and clarify the theory of human growth and behavior so that the supervisors can transmit it appropriately to the investigators in the course of their supervisory work. The supervisors attend the course for a full semester on agency time, the cost being borne entirely by Federal child welfare services funds. Since about one-third of them are graduate social workers and an even greater portion have already taken courses in human growth and behavior, the course's basic content is not new to most of them. Its focus on teaching, however, is new.

In order to insure the integration of the course material into agency practice, the supervisors meet in a workshop biweekly at the agency to consider specific ways of applying its general content in their specific supervisory practice. Since this phase of the program is still in process, we are not able to present our final impressions, but we believe the course has already stimulated a rich kind of thinking which will have its impact upon practice.

Aside from the program for the training unit supervisors, we have conducted regular workshops for all other unit supervisors—emphasizing the individualization of workers through the educational diagnostic methods of supervision.

The supervisors in the Bureau of Child Welfare know the job of the social investigator well. They are expert in knowledge of agency function and policy, and are becoming increasingly knowledgeable about sound social casework and child welfare practices. The chief area in which they need development, an area rarely emphasized in formal training, is methods of supervision—how best to teach staff and develop the worker's ability to operate with increasing independence.

We have concentrated on this area of staff development during the last 2 years. Perhaps in the next year we can move on to other areas and confine the development of supervisory methods to newly appointed unit supervisors. Our experience with these workshops has demonstrated that staff will rise to the opportunity to think and to learn, to reach for new ideas, and to participate wholly in the total learning experience.

Higher Staff

As one observes the various levels of staff in a public welfare agency, it becomes evident that the higher up the scale in the civil service promotional system, the older and more experienced the staff becomes and the further away from direct practice. Yet the group that should be most deeply concerned with staff development is the case supervisory staff. Just as the burden of practice has to be placed upon the unit supervisors who are the stable group of staff closest to practice, so the broader responsibility for improvement of both casework and supervisory practice ought to be assumed by the case supervisors. Therefore, before we even began to plan a program for unit supervisors, we involved the case supervisors in the development and evaluation of the supervisors' workshops. It took a little longer for the case supervisors to consider their own part in staff development, but after 2 years they too succeeded in using the opportunity provided to rethink casework practice.

Through a continuing series of meetings during the past year, the case supervisors reviewed and sifted every printed form used in the bureau, developed recommendations for modifying the use of a good number of forms, and suggested principles for the ways in which necessary forms might be used more productively by social investigators. At the present time the group is deeply involved in taking a fresh look at case recording in the bureau, examining the practices that the recording reflects, and considering the formulation of new goals in service that respond to the most up-to-date philosophy of child welfare practice. In the process of their meeting together, the case supervisors have been discovering a creative role for themselves in this overburdened bureaucratic structure. Perhaps soon they will no longer tend to view themselves merely as the third step up and third step down in levels of approval, but rather will recognize the special contributions they can make to the improvement of the bureau's practice.

The bureau's smaller group of senior supervisors serve as assistant administrators to division directors, their particular tasks residing in administrative areas. The administrative knowledge and experience in the senior supervisors' group have been tapped gradually in the staff development program, as we have observed specific areas that need attention. Last year the group met for many months to develop a report on ways of streamlining the social investigator's job. The focus of the case supervisors' work this year on forms and recording was a direct outgrowth of other recommendations the senior supervisors made. We are now contemplating the possibility of this group's undertaking a complicated plan to involve all levels of staff, but particularly experienced social investigators in all divisions of the bureau to develop a manual of practice for social investigators.

Administration

We cannot conclude a description of the bureau's staff development program without mentioning the part administration has played in carrying it out. The program could never have taken hold in the bureau without the deep conviction on the part of and administrative staff that "training is essential," but probably every agency administrator believes in such an axiom. It is when the theory is put to the test that one knows whether or not there is real support for staff development. When supervisors leave their desks to attend workshops and an extension course, when newly hired workers are started with only three cases in a division that has a dozen uncovered caseloads, when conflicts of time and interest appear, and when operation slows down to permit the entry of new ideas—then one knows that the step has been made, from abstract agreement with an idea to absolute professional support in the face of sacrifice, extra work, and the anxiety that accompanies the unknown.

Will this work? Will staff development become a state of mind and percolate through the agency? Will it help to retain staff or will it deplete staff even more by raising their sights and encouraging them to go to school and then to leave us for higher salaries? Is it best to have this program depend so utterly upon a gradual social work process, or should we implement a faster and more dramatic program involving outside experts, formal institutes, greater attendance at outside meetings, and the like?

The answers to these questions are appearing in the day-to-day responses of the staff to a staff development program that is already part of them and of their own making. The supervisory staff seems to have an inexhaustible willingness to examine their practice and their methods of supervision. In their natural reaching for new ideas they sometimes hesitate, but ultimately demonstrate their resiliency.

Staff development cannot help but be a dynamic process while staff itself is dynamic. However, assurance of the success of a program such as ours rests upon clear administrative support which must appreciate this dynamic response and must provide an atmosphere where imagination and experimentation can flourish; where the staff itself is honored. In an agency where there is the conviction that sound child welfare practice will derive from free inquiry into new ideas and knowledge, and where there is regard for the staff's own experiences and potentialities, a staff development program will grow out of staff need and desire. Such a program then cannot help but reflect the purposes and the practices of the agency.

Instead of becoming irritated and defensive about the labels of "do-gooders" and "proponents of the welfare state," we should accept them with pride, while asking what's wrong about doing good and urging a state of general welfare.

Whitney Young, Jr., to the Intergroup Relations Committee of the National Social Welfare Assembly.

SOME FACTORS IN ACHIEVING PSYCHOLOGICAL MATURITY

JOHN H. ROHRER

Professor of Psychology, Department of Psychiatry, Georgetown University School of Medicine

IN 1952, Allison Davis and John Dollard made available to the staff of the Urban Life Research Institute of Tulane University (New Orleans, La.) all of the original interview materials they had gathered in 1938 in a study carried out on a group of adolescent Negro youths in New Orleans. A part of that material had been published in their volume, "Children of Bondage."[1] The institute then formed a research team composed of a sociologist, an anthropologist, two psychologists, and two psychiatrists to make a followup study of this group. The study was carried out over a 3-year period. The major findings of this study are to be found in a volume entitled "The Eighth Generation."[2]

It is not my purpose to review that volume in this brief article. Rather I wish to point out some of the implications of the study's findings for a better understanding of the way an individual achieves some degree of psychological maturity.

In the study we tried to develop scientific descriptions at three different levels: the level of cultures; the level of social structures; and the level of intrapsychic functioning. We then attempted to integrate the findings at the three different levels into a coherent pattern explaining the lives of our subjects.

Negro culture in New Orleans is a fairly well integrated and mature one, having had eight generations in which to evolve. Certainly when one contrasts the degree to which the culture has become stabilized there with Negro communities in some other American cities, for example, Chicago, one is struck by the maturity of the New Orleans culture. Even so, this culture is not homogeneous, for we were able to identify at least five distinctive subcultural groups among our subjects differing markedly from one another in their value systems and their ways of life. Since our sample was preselected for us, we may have missed other subcultural groupings within the New Orleans Negro community—for example, an upperclass culture, of which the beginnings are now evident.

We were able to identify these subcultures through the study of five file drawers of material that we had collected on our subjects, identifying for each person we had interviewed what we call a *primary role identification.* By this we meant the central social role around which the person organized his secondary, tertiary, and other valued roles, and around which he organized his psychic economy.

For one group of subjects the subculture was the *matriarchy.* In this group the primary role identification was that of being a woman and was characterized by intense emotional feeling between mother and daughter, who presented a solid front, particularly when it came to excluding the male sex. Even when married, the daughters in this group saw their mothers as the center of their lives and security.

For another group the subculture was the *gang,* and the central role identification was that of being a man and being independent from mother, from wife and children, and, frequently, from occupation. The gang members had nothing but scorn for anything feminine, and particularly for effeminate men.

Another group was *family oriented,* the lives of the people in it revolving primarily, or even exclusively, around the family. For these men and women, family life was the most important part of all life, and family solidarity the most important value.

For another group, the orientation was *middle class.* For these people the things most valued were achievement, responsibility, respectability, politeness, industry, and kindred virtues.

As always when one is attempting to compartmentalize the complexities of human behavior, we had a residual group that we labeled *marginal.*

Thus we were able to demonstrate that for most people there is a central core role which is most highly valued and around which an individual orders all the rest of the behavior in which he engages. The selection of the central role identification, and the satellite roles which complement and support the central role, actually places limits on the different kinds of behaviors in which the person can engage. The values listed here for what we called our middle-class group indicate a range of behaviors that would make it impossible for a middle-class person to adopt the behavior of the gang-oriented person, and the values of the gang, in turn, would prevent a gang member from engaging in middle-class behavior.

It is this patterning effect that identifies the subcultures. The demonstration of the existence of such subcultures, even within one ethnic group, points to the considerable danger of making broad generalizations about the value systems and the ways of life of any ethnic or regional group.

A Factor in Mental Health

In the course of our work we gathered considerable information on the mental health of our subjects, although that was not the primary aim of our study. One of the most striking correlations we found between "good" and "poor" mental health was the relationship of our subjects during childhood and adolescent years with more mature individuals. Those individuals who had had significant adults in their lives providing them with emotional support in times of stress invariably were in a state of good mental health at the time of our study; those who were unfortunate enough not to have had such significant adults to provide emotional support were in poor mental health.

While in some cases the significant adult—the "ego ideal"—was a parent or parents, in others it was perhaps an aunt, a more mature cousin, or just a friend. Nor were these adults always of the same ethnic group. In one of the most striking success cases of all the subjects that we studied, that of "Little Bit" who turned out to be an internationally known dancer, the significant adult had been a white Dixieland band leader.

Another finding grew out of our decision to attempt to predict, from the early adolescent materials what the young person would be like as an adult. During our study each subject was seen by only one of the two psychiatrists. The other psychiatrist went over the old interview materials gathered some 15 years earlier and made "blind" predictions about what the individual would be like as an adult.

These predictions from the adolescent materials were based largely on the major types of ego defenses used, the types of gratifications sought, the dominant motivations exhibited, and the ways of relating to members of the same and opposite sex.

These predictions turned out to be amazingly accurate. The psychiatrists were able to predict in nearly all the cases the type of occupation a person would engage in, the level of education he would achieve, whether or not he (or she) would marry and, if so, the type of person the spouse would be and the degree of stability of the marriage. They were also accurate in predicting the habitual ways in which, as adults, our subjects would go about handling problems or conflicts.

Since the psychiatrists were using only the materials gathered during the subjects' adolescence on which to base their predictions, the accuracy of their predictions was interpreted to mean that an individual's techniques for maintaining his self-integrity and his ways of defending and enhancing himself were firmly established by adolescence. This underscores the considerable importance and significance of childhood and early adolescent development for the quality of achieved adult maturity.

In Summary

There are, of course, a multitude of factors that influence the achievement of psychological maturity, and I do not intend to indicate that the three basic factors mentioned here are all-inclusive. However, these three factors are fundamental to the achievement of any degree of psychological maturity. Everyone inevitably carries a number of social roles, some of which he identifies with more strongly than others. Everyone also, even after passing the great dependency of infancy, continues to have a need for warm emotional support during his formative years. Withdrawal of such emotional support, or failure to obtain it in times of stress, blocks the individual from becoming more mature. Finally, the fact, as evidenced by the predictions made by our psychiatrists, that the typical ways of adjusting to the world in which one finds one's self are established at least by early adolescence, indicates the great importance of these earlier years to the psychosocial maturity of an individual. This finding also indicates why it is a long tedious job, whether by counseling or psychotherapy, to modify these established, habitual ways of self-defense and enhancement.

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[1] Davis, Allison; Dollard, John: Children of bondage. American Council on Education, Washington, D.C., 1940.

[2] Rohrer, John H.; Edmonson, M. S. (editors): The eighth generation. Harper & Bros., New York, 1960.

An essay-review . . .

HELPING THE TROUBLED CHILD IN RESIDENTIAL TREATMENT

MARTIN GULA

Specialist on Group Care, Division of Social Services, Children's Bureau

WITH A BURGEONING population of over 64 million youngsters, our country is finding it increasingly difficult to identify, diagnose, and treat its emotionally disturbed children. Many such children remain unnoticed until adolescence when treatment is difficult. Many are identified and their condition diagnosed but never receive treatment because services are lacking. This gap between children in need and available resources will widen unless new methods are developed for locating and helping emotionally disturbed children and their families.

Currently, many individuals are involved in community efforts to keep children emotionally well—parents, teachers, ministers, doctors, psychiatrists, psychologists, social workers, and child care workers. Some communities have also developed a variety of resources for those who show symptoms of disturbance, including outpatient clinics and services and day hospitals.

Even with the best of community resources and outpatient services concerned with the emotional health of children, some emotionally disturbed children must be separated from their families for care and treatment. Many are being cared for in residential treatment centers, voluntary hospital psychiatric facilities, State and metropolitan mental hospitals, training schools, and child-caring institutions of various kinds. Unfortunately, many of these emotionally disturbed children are committed to State hospitals for adults or training schools and children's institutions which do not have adequate clinical facilities and coordinated treatment service.

However, a small but growing number of residential treatment centers have devoted themselves to creating therapeutic settings for the treatment of disturbed children and counseling or treatment of parents. Some of these centers are sponsored by medical or mental health organizations. A larger number have been developed by child welfare organizations.

One result of intensive welfare efforts is Hawthorne Cedar Knolls, a residential treatment facility promoted by the Jewish Board of Guardians in New York. Since 1935, Hawthorne has experimented with a variety of therapeutic disciplines for developing a constructive treatment setting for children. The integration of these disciplines is described in "Residential Treatment for the Disturbed Child,"[1] by Herschel Alt, executive director of the parent organization. In his words, ". . . the roots of residential treatment are to be found in many fields of social and psychological service, as well as in the child-rearing disciplines."

Several other efforts have been made to identify these elements of residential treatment.[2,3] They include the following: selective grouping, concurrent help for parents, individual psychotherapy, group care, group therapy, remedial education, somatic therapies, and medical services. Listing the elements is comparatively simple. The challenge is how to coordinate and integrate these elements in such a way as to offer the greatest benefit to the individual child and the resident population as a whole.

An Integrated Program

At Hawthorne, such integration is pursued vigorously. "The child is one and indivisible, and if the specialized services are to contribute most to his healing and growth, each distinct function must be in harmony with the others." A variety of integrative devices are used: "initial and followup conferences on individual children, inservice seminars, a common educational base which comes from similar training and also . . . incorporation into the milieu of common attitudes and values." Professional supervision is provided for cottage parents, who participate in case discussions and in general policy decisions about care of children. The institution has been subdivided into small treatment units ". . . which makes for more focused efforts" and "also helps to facilitate communication, common purpose, and consistency of effort."

Although many gains have been made in integrating staff treatment efforts, Alt believes that much more has to be learned about the interaction of specific child care procedures and clinical treatment in a total treatment plan. "The important thing, too, in addition to the warmth and investment in the concern for the real child and his total life, is that the institution maintain a philosophy which both totally and uniformly incorporates basic mental health principles. This does not mean transforming the whole institution into one large therapy room, nor does it mean indifference to the discrepancies between what is expected in real living and what can be allowed in the therapeutic relationship."

It is probably safe to assume that no two residential treatment centers will arrive at precisely the same theoretical formulation of their treatment base and methods of integrating all aspects of treatment. However, the important goal is for every treatment center to begin to be conscious of the way it is developing its internal practices and its relationship to external community services for disturbed children.

Herschel Alt's description of the development of Hawthorne Cedar Knolls could inspire some soul searching in other treatment centers. His frank discussion of theoretical and practical limitations is a warning to those professing to have unqualified "answers." The example of Hawthorne's embracement of many social, medical, psychological, psychiatric, educational, and child-rearing disciplines could be stimulating to those facilities with narrower reliance on fewer disciplines. The description of Hawthorne's purposeful relationship to other agency and community services for disturbed children should help to counteract the isolated role of some residential treatment centers. Hawthorne's emphasis on evaluation of treatment and research is basic to good treatment.

Case Illustrations

One way to gain an understanding of a residential treatment center is to study its treatment of an individual child and his family. Herschel Alt does this for three children in the book. The treatment of "Lenny," for example, began with a severely delinquent, apparently psychopathic youngster. Lenny's delinquency was an "accepted way of life." He had little guilt or anxiety, little capacity for relating to people constructively, and "requirements for effective psychotherapeutic intervention were absent."

Lenny's behavior included gang fights, truancy, running away from home, and car stealing. Hawthorne discovered that Lenny had strong hostility toward an itinerant mother and a fear of being "no good." He took it out on the world with a "bigshot" attitude and aggressive acts. Treatment of the boy involved a fascinating interplay of a warm, strong cottage couple; a therapist who could not be "outwitted;" confronting Lenny with his emotional patterns; an "incorruptible" school; and "boxing" the boy in by total staff when necessary. After 2 years at Hawthorne, Lenny returned to live with his mother, obtained and held a job, and did not—at least up until the time the book was written—become involved in any further delinquency.

Hawthorne has its failures too. But a case like Lenny's illustrates that even children who at first glance seem to have few strengths to build on can be helped to emotional stability with a careful combination of the various aspects of treatment available in such a comprehensive and integrated program as this residential treatment institution provides.

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[1] Alt, Herschel: Residential treatment for the disturbed child. International Universities Press, New York, 1961. $7.50. 437 pp.

[2] Reid, Joseph H.; Hagan, Helen: Residential treatment of emotionally disturbed children. Child Welfare League of America, New York, 1952.

[3] American Psychiatric Association: Psychiatric inpatient treatment of children. Washington, 1957.

HERE AND THERE

Adolescent Health

The broad vista of special health services for adolescents in this country was explored in an exchange of ideas and stocktaking by 65 professional workers from 15 adolescent clinics who met in Denver for a 2-day Conference on Adolescent Medicine in mid-April 1961. Sponsored jointly by the Division of Maternal and Child Health of the Colorado Department of Public Health and the University of Colorado Medical School, the conference brought together pediatricians, internists, psychiatrists, medical social workers, nurses, psychologists, research workers, and nutritionists. The discussions revealed that:

- Patterns of staff composition in adolescent clinics vary widely according to the kind of facility in which the clinic is set up—in a psychiatric unit, for example, or in a university's pediatric outpatient department—the older clinics generally having a greater variety of disciplines than the newer.
- Adolescent units not giving primarily psychiatric services are alike in that they see all children from 12 to 18 or 21 years of age referred to the hospital's outpatient department except those admitted for acute diagnosed disorders or emergencies. A pediatrician or internist becomes the adolescent's "own physician" to whom the specialists are then consultants. Nearly all such clinics have medical social workers on their staffs.

The discussants emphasized the close association between medical problems which are normal for the adolescent and those that are social or educational; the many areas in which norms for this age group need defining; the value of close rapport with community agencies and individuals working with youth; and the need for delineating goals and responsibilities for nonpsychiatric help to the adolescent coping with emotional difficulties.

Research was reported as ongoing or planned in the fields of language development, nonachievers in education, anthropomorphic measurement standards; correlation of onset of puberty with other physiologic and psychological developments; relationships of self-perception and emotional dependence with social behavior; the thought-style of the adolescent and the relationship of problem-solving abilities to other behavior, to metabolic and physiologic effects on mental and behavioral functions, and to genetic makeup; endocrine patterns as related to nutritional habits and to growth and development; school readiness; and methods of professional communication with adolescents.

Agreement was virtually unanimous that the need to know more about adolescents while trying to meet their special requirements justified having special services for them. The participants also agreed, however, that by so specializing there is a danger of not maintaining the reality of a continuum of care based on the normal continuity of growth and development from infancy to adulthood.

—Georgia B. Perkins

Unemployed Youth

The existence of thousands of unemployed youth in the slums of our large cities is "social dynamite," said James B. Conant, scientist and educator, to the 400 persons who met together in Washington, May 24–27, at the Conference on Unemployed Youth in Urban Areas. Convened by the National Committee on Children and Youth, and financed by the Ford Foundation, the conference drew participants from 38 States with a planned concentration on 15 of the country's largest cities. Besides representatives of the National Committee and its constituent organizations, the participants included representatives of labor and industry, educators, employment counselors, social workers, public health personnel, and local youth committee executives and members.

Dr. Conant, who served as chairman of the conference, told of his shock in learning on visits to several large cities that the employment of youth is "literally nobody's affair." He described a slum section composed almost entirely of Negroes where 59 percent of the male youth between the ages of 16 and 21 were out of school and unemployed—48 percent of the male high-school graduates and 63 percent of the boys who had dropped out of school. Unless management and labor take up the challenge to provide jobs for these young people, who now can see no pathway out of the slums, Dr. Conant said, a public works program may have to be provided to alleviate the problem. He also advocated the assumption by the schools of the responsibility to provide vocational and educational counseling for out-of-school young people until they are 21.

High government officials also attested to the seriousness of the problem. Vice President Lyndon B. Johnson, at a dinner meeting, maintained that the young person who drops out of school in this country is just as illiterate when measured against the needs of young people in our society as the boy or girl in Asia who never gets to school.

At a luncheon meeting Secretary of Health, Education, and Welfare Abraham A. Ribicoff emphasized the importance of local experimental programs in schools in underprivileged areas. Secretary of Labor Arthur J. Goldberg stressed the part played by racial discrimination in keeping many young people from getting the kind of education, training, and jobs they need. "If you want to do something for your country," he said, "stop discriminating." Attorney General Robert F. Kennedy, in a speech read for him, stressed the connection between unemployment and youth crime, and called for a broad concentrated effort to "narrow the gap between the legitimate aspirations of our youths and the opportunities available to them."

Ewan Clague, Director of the Bureau of Labor Statistics, Department of Labor, gave a picture of the size of the problem: 450,000 boys and girls between the ages of 16 and 20 reported themselves out of school looking for work in October 1960, about 265,000 of them in the 15 cities on which the conference focused. Reporting on studies showing that school drop-outs experienced three to four times as much unemployment as high-school graduates, he advocated the development of combination study-work programs for young people as well as efforts to impress upon them the importance of quality performance.

Speakers from labor and industry

also expresed concern over the problem; and administrators of large city school systems pointed to the obstacles of insufficient staff and money impeding efforts to cope with the situation.

Thirteen workgroups spent three 3-hour sessions seeking solutions. In summarizing their recommendations at the final meeting, Roy Sorenson, director of the YMCA of San Francisco, found 12 common denominators:

1. Strengthening the schools—in regard to curriculum, teacher training, counseling and guidance, visiting teachers and psychologists, identification of drop-outs, the provision of work experience, smaller classes, preparation for reentrance into school, and parent education.
2. Extension of special employment services for youth.
3. Coordination of schools and employment services.
4. The provision of job opportunities for beginners.
5. Action by labor and industry in behalf of youth.
6. Efforts to improve youth's self-image through opportunities for meaningful activity in cultural and community affairs.
7. Reduction of job discrimination against race and age.
8. Government financial aid and leadership for youth programs, including the creation of an urban service corps of youth.
9. Organization for the community's acceptance of responsibility.
10. Efforts to awaken public awareness to the problem.
11. Research for facts to energize action and define the problem, neighborhood by neighborhood.
12. Followup of the conference in various ways, especially by each representative taking the initiative to get something started in his own community.

—K. C.

Conference on Mental Retardation

Social services for mentally retarded children and their families was the focus of a national workshop on mental retardation for social workers, held April 3–7, in Miami Beach. The participants were social workers employed in diagnostic and evaluation pediatric centers for mentally retarded children in the maternal and child health programs of 32 State health departments. The conference was sponsored by the Florida State Board of Health; the Developmental Evaluation Clinic, Dade County Department of Public Health; and the U.S. Children's Bureau.

The workshop came about in recognition of the expressed needs of these social workers and the recommendation of the technical advisory committee to the Children's Bureau on clinic programs for mentally retarded children. While clinic teams have met on a regional basis from time to time and thrashed out mutual problems, this was the first time clinic social workers from all parts of the country have been convened.

The keynote speaker for the workshop was Edith Baker, chief of social service, Bureau of Maternal and Child Health, District of Columbia Department of Public Health, who placed social workers' activities in these clinics within the framework of the overall maternal and child health program, stressing preventive as well as treatment services.

The workshop considered three subjects. The discussion of the first, clinical social-work practice, brought out the realization that areas needing further emphasis and study were the family-centered approach, groupwork with parents, waiting lists, and selection of priorities in clinics seeing many children.

The second subject was the use of social-work skills to develop community resources for mentally retarded children in both urban and rural communities. The identification of general concepts of the development of community services was followed by specific examples of how they were applied, such as the extension of services by a central clinic to residents of adjoining counties.

The third focus of discussion was on research studies of social factors influencing mental retardation and the effect of social work intervention on social malfunction. The discussion of this went into the determination of what questions were researchable and how to go about setting up a research design. Out of this part of the workshop came an expressed need for further smaller workshops for persons primarily interested in exploring this subject further and for the establishment of a clearinghouse to make it possible for comparable research studies to be started in more than one clinic.

Other recommendations made by the group were for yearly workshops for the entire group and smaller sectional meetings on such subjects as groupwork with parents and teaching of other professional personnel.

—Mary E. Watts

For Migrants

A uniform personal health record form for migrant agricultural workers and their families has recently been produced by the Public Health Service and distributed to State health departments, from which they can be secured by local and voluntary agencies. The form was recommended by the Association of State and Territorial Health Officers at their 1960 conference in San Francisco last October.

The cover of the record provides space for the migrant's name, home address, sex, and birthdate or age. A note in English and in Spanish advises him to show the record whenever he goes to a doctor or a nurse. A note to physicians and nurses requests them to enter pertinent information and return the record to the bearer.

The entry sections of the form provide space for records of immunizations, laboratory tests and results, obstetrical history, and important clinical conditions. In the last two sections, the name and address of the person making the entry are requested.

The forms, 10½ by 4 inches, have space on both sides for other information pertinent to the migrant's health. Folded, they can be carried in his billfold or pocket.

Social Workers

On December 1, 1961, the Academy of Certified Social Workers, a new arm of the National Association of Social Workers, will begin certifying social workers who meet the qualifications set up in a national certification plan developed by the association at the request of its membership. Early this spring the academy began mailing application blanks to the association's 28,500 members. Some 10,000 aplications were filed during the first month.

The National Association of Social Workers now requires a master's degree in social work to join. Most members will be eligible for certification on December 1 if they have had both 2 years of membership in the association and 2 years of paid employment as a social worker. Other association members on that date will have 2 years to meet those conditions, but persons entering the association later will have to meet more extensive requirements. According to present plans, the criteria for certification will eventually include measures of competence as well as education and experience.

The association has also announced its intention to continue work toward the passage of State laws providing for legal regulation of social work practice.

For Health

The Boston area has the highest ratio of physicians to population among the 17 metropolitan areas with populations of a million or more, according to a health manpower report issued by the U.S. Public Health Service. In the Boston-Lowell-Lawrence metropolitan area, where the ratio is highest, there were 207 active non-Federal physicians per 100,000 people in mid-1959. The San Francisco-Oakland area ranked second with a physician-population ratio of 199, and the New York-northeastern New Jersey area, with a ratio of 189, third. Lowest ratio in these great metropolitan areas was 111, found in Detroit area.

In 157 metropolitan areas with fewer than a million people, the ratios of physicians to population ranged from 459 per 100,000 persons (Ann Arbor, Mich.) to 39.

In the larger metropolitan areas, the proportion of physicians in private practice was greatest—77 percent—in the New York-northeastern New Jersey area. The Baltimore area had the greatest proportions in hospital service, teaching, and other salaried positions—38 percent.

Entitled "Health Manpower Source Book, Section 10: Physicians' Age, Type of Practice, and Location," the report (PHS Publication No. 263, Section 10) is available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Price 55 cents.

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The Mental Retardation Training Center at Tulsa, Okla., a special project of the Children's Bureau and the Oklahoma State Department of Health, gave its first course for nursing instructors February 20–24, 1961. Twelve instructors from Oklahoma schools of nursing attended the course, which was composed of lectures, discussions, and demonstrations concerned with the normal growth and development of infants and methods of detecting deviations, the effects on the parents of diagnosis of retardation in a child, methods of parent counseling, the necessity of cooperation between hospital personnel and public health nursing services, the kinds of community facilities needed to serve retarded children and their families, and the use of films, publications, and other teaching tools in training personnel to work with the retarded. Included was a team demonstration of an evaluation of two children.

The course was planned by a committee representative of the Oklahoma State Board of Nurse Examiners, the Oklahoma League for Nursing, The Tulsa-City County Health Department, the Oklahoma State Department of Health, and the Federal Children's Bureau.

. . .

A "total-care" attack on long-term childhood diseases overlapping a number of medical specialties has been underway in a clinic of the University of Michigan Medical Center at Ann Arbor, where approximately 600 patients have been helped during the first year. Launched in early spring 1960, the total-care clinic, which is held weekly, permits simultaneous study of a child's ills by a number of specialists.

An extension of the team-treatment pattern used at the medical center for burn victims and patients with cleft palate, the new approach includes specialists in pediatrics, neurology, orthopedics, physical medicine, and arthritis, and in other fields as needed. A medical social worker is also in the group.

Peace Corps

By late spring, the Peace Corps (see CHILDREN, May–June 1961, p. 114) had specific projects in preliminary stages of operation for three newly developing countries and requests for Corps volunteers from 24 nations. The Corps plans to send 28 surveyors, geologists, and civil engineers to Tanganyika in early October to map out roads in the barren bush country. A 7-week training course, now underway at a western university with climatic and geographic conditions resembling those in the project country, includes 4 hours a day of Swahili, the common language of Tanganyika.

Another group of 64 volunteers is slated to begin work on rural development projects in Colombia in the fall of 1961. About twice the number of recruits needed are being trained by Rutgers University in Latin American politics and culture, drilled in language, and refreshed in the latest of agricultural techniques. Those trained but not selected will remain in the Peace Corps reserve.

Scheduled to begin arriving in the Philippines during the first part of November are 300 Corpsmen who will assist local elementary school teachers in English instruction and in general science subjects.

Trainees for these projects first passed examinations for Peace Corps applicants held in May and June, which tested, among other things, competence in technical fields or special skills.

Other projects in the planning stage include those growing out of an eight-country tour of Asia and Africa by Corps Director R. Sargent Shriver. Of 3,500 volunteers requested, Nigeria alone asked for 1,200 and Ghana, 300.

Social Work Manpower

Completed figures from a survey of social welfare personnel carried out in the spring and summer of 1960 showed a total of 116,000 persons holding positions as social welfare workers in 1960, a rise of 42 percent since 1950, the last year a national survey was made. The survey was conducted by the Bureau of Labor Statistics of the Department of Labor in cooperation with the Department of Health, Education, and Welfare and the National Social Welfare Assembly. (See CHILDREN, March–April 1960, p. 77.)

The survey also showed that salaries of social workers had appreciably increased during the period, the national average of 1960 being $5,220, a 76-percent rise since 1950. (During the period the Consumer Price Index rose 23 percent.)

Among the 116,000 social welfare workers (including some 10,000 recreation workers), 64 percent were employed by government agencies, the great majority of them by State and local agencies. Public assistance, with 30 percent of the workers, and child welfare, with 21 percent, absorbed the largest portion of workers. Sixty-two percent of the total were in direct service positions.

Though only 25 percent of all social welfare workers had graduate degrees, 50 percent had had some graduate study, 33 percent in a school of social work. However, 29 percent of the total had not achieved a bachelor's degree.

The overall report of the study, "Salaries and Working Conditions of Social Welfare Manpower in 1960," is available from the National Social Welfare Assembly, 345 East 46th Street, New York, 17, at the price of $1.75.

Besides data on employment characteristics, education, work experience, and salaries, the survey also includes information on employment practices and supplementary benefits. The data were gathered from 531 counties selected as sampling areas and through a 100-percent survey of social workers in federally aided programs.

Detailed data collected from this survey of social welfare workers in federally aided programs are being released in separate reports by the Department of Health, Education, and Welfare. A joint report from the Bureau of Public Assistance and the Children's Bureau shows a 74-percent rise in social welfare workers in public child welfare programs during the decade. It also shows that the proportion of child welfare workers with full professional education in social work had gone up from 20 to 26 percent, and that the proportion lacking bachelor's degrees had dropped from 16 to 9 percent. However, the proportion of child welfare workers with no graduate social work education rose from 40 to 46 percent. The median salary for a caseworker in child welfare in 1960 was $4,553, representing a 68-percent rise since 1950.

In public assistance the total number of social welfare workers rose from 29,900 to 34,500. In the supervisory group the proportion with full professional education in social work increased from 10 percent to 13 percent. However, the proportion of caseworkers with full professional education dropped (from 2 to 1 percent) as did the proportion of caseworkers with some graduate social work study (from 17 percent to 11 percent). The proportion of caseworkers with no college degree—about a third of the total—remained about the same. Public assistance salaries also increased, so that only 16 percent of the caseworkers were receiving $3,600 or less, compared with 98 percent in 1950.

Data on social welfare workers in public health programs will be published by the Public Health Service in the near future.

Federal Legislation

Two measures broadening the scope of the aid-to-dependent children program for a period of 14 months were among a group of amendments to the Social Security Act passed by the 87th Congress, with the effective date of May 1. The two actions brought under ADC coverage (1) children of unemployed parents, and (2) children who are removed from their homes by courts of competent jurisdiction because of inadequate protection and care and are placed in foster family homes.

The amendment authorizing the Federal-State ADC program to be extended to children of unemployed parents now allows needy children to receive assistance while both parents remain in the home—a situation not previously possible if one of the parents was employable. The usual breadwinner in such families is, however, required to use the State employment services, and the State has the option to exclude families receiving unemployment compensation. State agencies administering the program must encourage the retraining of individuals capable of being retrained through arrangements with State vocational education agencies.

The foster-care amendment modifies the provision which has limited ADC coverage to needy, dependent children who are living with their parents or with specified relatives. Now, Federal matching of funds is authorized for State payments on behalf of children who have been placed in foster family homes after May 1, 1961. The children must have been eligible for assistance under the program before placement and have received aid for the month in which removal proceedings were begun. Included in the amendment is the requirement that the State provide for "development of a plan for each such child (including periodic review of the necessity for the child's being in a foster family home) to assure that he receives proper care and that services are provided which are designed to improve the conditions in the home from which he was removed . . ." In placing the child, the administrators of the aid-to-dependent-children program are required to use "to the fullest extent practical" the services of personnel in the public child welfare program.

The Senate committee reporting on the amendment before its passage noted that some States "have placed in operation statutes terminating payment when a child's home is found unsuitable because of immoral or negligent behavior of the parent." (See CHILDREN, November–December 1960, p. 241, and January–February 1961, p. 36.) The committee report expressed the opinion that remedial action on behalf of the child often was not possible and that this situation could have been avoided if "assistance under the program were available for the care of the child in a foster family home."

In another amendment Congress postponed from July 1, 1961, to September 1, 1962—for States with statutory impediments to compliance—the effective date of a ruling made by the Department of Health, Education, and Welfare, under former Secretary Arthur S. Flemming, to cut off Federal funds to States that deny ADC payments to children in "unsuitable homes" without otherwise providing for the care of the children. (See CHILDREN, March–April 1961, p. 73.)

Another amendment to the act raises the authorization for Federal participation in the financing of grants for training public welfare personnel for public assistance agencies from 80 to 100 percent, during the period July 1, 1961, through June 30, 1963. (No appropriation has been made for this type of activity since it was first authorized in 1956.)

White House Conference

The final collection of papers from the 1960 White House Conference on Children and Youth, "Values and Ideals of American Youth," edited by Eli Ginzberg, came off the press in late May. (Columbia University Press, New York, price $6.) Composed of selected papers prepared for the conference and addresses delivered at the Washington meetings, the book is divided into three parts: I. "Development and Adaptability"; II. "Problem Areas"; and III. "Values in Transition."

Part I contains papers on the possible effects of a changing world on young people's development and opportunities, and the qualities necessary for healthy adaptation.

Part II contains papers on the special problems confronting or presented by some young people today—poverty, juvenile delinquency, racial discrimination, reckless driving, and pornography.

Part III includes papers on the methods and climate required for the teaching of values and responsibility, and the nurture of creativity.

Included among the 22 authors are a physical scientist, psychiatrists and other physicians, psychologists, educators, a lawyer, sociologists, social workers, public health educators, and religious leaders.

• • •

The American Jewish Committee, Institute of Human Relations, has recently issued a pamphlet, "Guidelines Toward Human Rights," composed of all the recommendations on human rights, intergroup relations, and related issues from the forums of the 1960 White House Conference on Children and Youth. The recommendations are presented under categories designed to be useful in programing: civil rights, community organizations and services, discrimination in education, educational policy, employment, health, housing, intergroup relations, mass media, recreation, research, and youth participation in community affairs. The pamphlet is available from the committee, 165 East 56th Street, New York 22. (Price 20 cents, less, in quantity.)

Juvenile Delinquency

In order to coordinate and broaden Federal efforts to help States and localities combat juvenile delinquency, President Kennedy in mid-May established by executive order the President's Committee on Juvenile Delinquency, composed of the Attorney General, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, with the Attorney General as chairman. The President also directed the establishment of a Citizens Advisory Council of not less than 12 or more than 21 persons to work with the Committee.

The executive order charged the President's committee with four functions relating to juvenile delinquency and youth crime.

- To review, evaluate and promote the coordination of Federal activities.
- To stimulate experimentation, innovation, and improvement in Federal programs.
- To encourage cooperation and information exchange among Federal, State, and local organizations with similar interests.
- To recommend measures to Federal departments and agencies for more effective prevention, treatment, and control.

The Citizens Advisory Council, whose members and chairman are to be designated by the Attorney General, is to be composed of persons who are recognized authorities in professional or technical fields, or leaders in programs concerned with juvenile delinquency or youth crime.

David L. Hackett, a special assistant to the Attorney General, has been named executive director of the President's committee. Lloyd E. Ohlin, professor at the New York School of Social Work, has been appointed special consultant on juvenile delinquency for the Department of Health, Education, and Welfare.

• • •

Results of a recently completed study to gauge the effects of training school experience on personality, carried out at the Michigan State Girl's Training School, showed that 70 percent of the girls tested showed fewer liabilities associated with mental health after a year in the school, while 30 percent showed an intensification of such liabilities.

The study involved testing of 120 girls within the age range of 12 to 17 years both on admission and after a year with a questionnaire measuring personality liabilities such as: behavioral immaturity, emotional instability, feelings of inadequacy, physical defects, and nervous manifestations. Also measured were such assets as close personal relationships, interpersonal skills, social participation, satisfying work and recreation, and adequate outlook and goals. Sixty-five percent of the girls tested showed an increase in assets associated with mental health, whereas 35 percent showed a decrease in such assets.

The study was carried out by Merle Smith, staff psychologist, and Norman G. Tolman, supervisor of psychological services, who suggest that its results indicate the need for a testing instrument to identify girls at admission to the school who are likely to be damaged by the training school experience.

• • •

A project integrating vocational training and treatment of emotionally disturbed, delinquent boys at Children's Village, a voluntary institution for the treatment of juvenile delinquents in Dobbs Ferry, N.Y., recently received funds from the Office of Vocational Rehabilitation for the first year of operations out of a grant of some $209,500 for a 5-year period. The participants are boys with limited education, lack of previous vocational direction, a belief that the good things in life are unobtainable, behavior standards that are unacceptable, inability to delay satisfying immediate wants, and lack of self-confidence.

Under the project the boys will continue to receive the integrated service after they return home. Designed to include continuous evaluation of its effects, it will test whether vocational rehabilitation, by enhancing the boys' potential for economic productivity, can help them to acquire more self-respect, stimulate them to want more education, and reduce their antisocial activity.

Child Welfare

In Maryland, less than a third of the 4,409 children in foster care were born out of wedlock, and about 64 percent were living with one or both parents when coming into such care, according to a statewide study on child welfare recently completed by the State department of public welfare. Entitled, "Maryland's Public Child Welfare Programs," the report covers data on foster care, adoptive, protective, and after-care services, both public and private.

Among other facts brought out were:

- As of March 31, 1959, nearly 10,000 children were receiving child welfare services. A little more than 18 percent received service from private agencies, the rest from public. More than a half of the welfare total was in foster family or adoptive homes.
- Of the 1,209 children in protective service, about two-thirds came from the counties rather than the city. Out of the 788 from the counties, 610 were white; while the city total of 421 included 87 white children.
- More than three-fourths of the 436 children receiving after-care service on their return from training school for delinquents were from families who

were not receiving public assistance.

The study data will be the springboard for special studies, such as on children in foster care over a number of years, with implications for ways to reach families earlier and for improving the chances for children to remain in their own homes.

. . .

The Citizen's Committee for Children of New York, Inc., has launched a campaign to secure a protective casework service for neglected children and their parents within the child welfare program of the New York City Department of Welfare. In a report, "Protecting New York City's Children," released at the opening of the campaign, the committee argues that the right to pursue a complaint must be lodged in a public department since "citizens understand legal authority delegated to a public department and also know that provisions exist to protect their rights." In 1960, according to the committee, there were 3,564 neglect petitions before the New York City courts, many of which might have been prevented if service had been provided to the family earlier.

The report, prepared by Alfred J. Kahn, is to be included as a chapter in a book "Community Strategy and the Delinquencies," to be published by the committee late in 1961.

. . .

The Kentucky Department of Child Welfare is in the process of setting up a "child accounting system" including all children receiving welfare services through the department. This system will serve as a basis for planning for each child. Initial accounting and planning began with all of the children in foster care.

. . .

West Virginia has developed comprehensive schedules for the study of children in foster care within that State. Carried out by the State department of public assistance, the study is part of the groundswell of stocktaking among the Nation's child welfare agencies, generated by the Maas-Engler study under the auspices of the Child Welfare League of America. (See "No Homes of Their Own," by Wayne Vasey, CHILDREN, July–August 1960, p. 155.) Of particular concern in the West Virginia study are the children without meaningful relationship with their own families and for whom foster care has become a permanent way of life.

Analysis of data from the schedules—each of which will be completed by the child welfare worker assigned to the child—will answer such questions as these about children in foster care:

How long have they been in such care? Which children should or can be adopted? Which ones are different from those being adopted and how are they different? What can be learned about the unadoptable that will serve as guideposts in preventing others from growing up without families of their own?

. . .

Public and voluntary agencies are taking part in a new study of characteristics of children receiving child welfare services being conducted by the Children's Bureau in cooperation with the Child Welfare League of America. A previous study by the Bureau covered all children receiving child welfare services in 45 States through public agencies only. Findings of this survey were published in 1960. (See "Children Who Receive Services from Public Child Welfare Agencies," Government Publications, inside back cover.)

Guides and Reports

THE PEDIATRICIAN'S ROLE IN PREVENTING DELINQUENCY. American Academy of Pediatrics, 1801 Hillman Avenue, Evanston, Ill. 1960. 32 pp. Single copies free from the Academy.

This discussion of specific ways in which a pediatrician can assist in the study, treatment, prevention, and understanding of juvenile delinquency, identifies the pediatrician's major contributions in the area of prevention as derived from his roles as an adviser to parents, community worker, teacher, and researcher.

THE CASEWORKER; person with value. Mary Overholt Peters. American Public Welfare Association, 1313 East 60th Street, Chicago 37. Series on Services and Training, III. 1960. 26 pp. 75 cents. Discounts on quantity orders.

One of a series planned to help State and local public welfare agencies in effective implementation of recent amendments to the Social Security Act, this pamphlet discusses ways in which the public assistance worker can use the client-worker relationship to help strengthen family life.

HELPING PARENTS OF HANDICAPPED CHILDREN. Children's Hospital Medical Center; and Child Study Association of America, 9 East 89th Street, New York 28. 1961. 40 pp. $1.25.

Proceedings of a 1959 conference focused on preventive mental health methods for chronically ill or disabled children and their families, including papers on the psychiatric implications underlying parental concern for handicapped children, and on community planning for their parents.

PROFESSIONAL SALARIES IN MENTAL HEALTH CLINICS AND HOSPITALS, Ralph Anderson, Editor. Des Moines Child Guidance Center, 1206 Pleasant Street, Des Moines, Iowa. 1960. 12 pp. Single copies, 35 cents; 10 or more, 25 cents each.

Results of a survey of salaries offered professional workers in 213 mental health facilities, inpatient and outpatient, with full-time staffs including at least a psychiatrist, a clinical psychologist, and a psychiatric social worker, are reported for the 50 states of the United States, Canada, and Puerto Rico. Data, covering filled and unfilled positions in these three professions and other related positions, are compared with a previous survey.

BOOK NOTES

RECENT DEVELOPMENTS IN PSYCHOANALYTIC CHILD THERAPY. Joseph Weinreb, editor. International Universities Press, New York. 1961. 178 pp. $5.

A collective discourse on the mutual enrichment of psychoanalysis and child guidance, this book presents the work of 17 participants in a symposium sponsored by the Worcester Youth Guidance Center in Massachusetts.

The first part comprises a paper by Anna Freud on adolescence—which she calls the "stepchild of psychoanalytical theory." She also contributes to the book's second part, on the child guidance clinic as a center of prophylaxis and enlightenment, in which other participants discuss work with physicians and with teachers.

In part 3, the papers treat aspects of diagnosis and selection, including the process of intake as an aid in the determination of treatability; and the use of prediction in longitudinal study.

The fourth part concerns selected treatment situations: the treatment of under-fives by way of their parents; the application of psychoanalytic knowledge to children with organic illness; and borderline states in childhood and adolescence.

THE INFORMED HEART; Autonomy in a Mass Age. Bruno Bettleheim. The Free Press, Glencoe, Ill. 1960. 309 pp. $5.

Concerned with the danger of an abrogation of spontaneity and of individual decision-making in an increasingly complex and comfort-producing society, the author of this book draws on both his professional experience as a child psychologist and his personal experience in a Nazi concentration camp more than 20 years ago in suggesting the dangers to individual happiness and to a free society in the loss of personal autonomy. In a day of scientific progress, he warns, man needs a much more highly integrated personality than in a period of less rapid change and fewer choices. Without this, he suggests, the seductiveness of mass persuasion and the tendency to leave decisions to the experts weakens inner controls and the ability to achieve satisfactions—"a condition which may lead to dangerous inertia or to explosions of instinctual violence."

Presenting his concentration camp observations as evidence that environmental stress can change the personality of a mature adult—either for better or for worse—he reviews these in an effort to identify those factors in personality which enable man to stand up in any environment, even one created for the purpose of dehumanizing the individual. While his own chief concern as a prisoner was to survive without changing as a person, in the face of a daily regimen of indignities, hunger, and fear, his chief device for doing this was to maintain his professional interest in studying human behavior, by observing his fellow prisoners and trying to learn why some managed to keep their personalities intact and others disintegrated quickly.

Those whose personalities held up, he reports, were not those who psychoanalysts would have predicted would be strongest under stress, but those who in spite of possible neurotic traits could maintain the interests from which they had derived self-respect, whether this was a religion or a strong intellectual interest. What seemed to matter most to the maintenance of integrity, he says, was whether or not the prisoner was able to carve out some freedom of action and thought for himself, however small. What produced change, whether for good or bad, he observed, was a person's own behavior, for "how a man acts can alter what he is."

THE TEEN-AGE YEARS; a medical guide for young people and their parents. Arthur Roth, M.D. Doubleday & Co., Garden City, N.Y. 1960. 288 pp. $3.95.

Why a teenager may act like an exhausted old man one minute and turn into a bundle of energy the next, or why a strapping football player may keel over while waiting for a routine immunization shot are among the enigmatic features of adolescent behavior unraveled in this guidebook for the laity. At the outset, the author describes the teenage years as a "second infancy," in which the search for personal identification is accented by "the impatient reaction of youth on the threshold of adulthood."

The author advises on the gamut of medical, paramedical, and behavioral topics related to adolescence—from acne to late hours—drawing heavily for illustrations on his professional experience in a clinic for adolescents. Following a detailed account of expected physical changes accompanying growth and development, he calls attention to the wide range of differences within the concept of normality and warns against setting up impossible goals of physical and mental attainment for young people.

Anxieties among teenagers, he points out, are commonly caused by fatigue—often brought on by heavy social and school involvements—weight, and skin disorders.

The author, a founder-director of the teen-age clinic, Kaiser Foundation Medical Center, Oakland, Calif., maintains that rapport with teenagers can best be established by a family doctor.

OUR OBSTETRIC HERITAGE; the story of safe childbirth. Herbert Thoms, M.D. The Shoe String Press, Hamden, Conn. 1960. 164 pp. $4.75.

Tracing the advance of obstetrics from folklore to science, the author, a medical historian and obstetrician, sketches the biographies of people who helped clear the hurdles of "ignorance, superstition, and prejudice." Among them were Smellie, Semmelweis, and Oliver Wendell Holmes, who believed puerperal fever to be infectious long before the theory was widely accepted.

Chapter subjects include the renaissance of obstetrics, the "with-women," the great teachers of the 18th century, and the cesarean section, which the author calls the greatest as well as the oldest operation.

Stellar American contributions in this specialty were in obstetric teaching and hospital care, the author points out. Together with such medical breakthroughs as the discovery of antibiotics and the Rh blood factor, they helped reduce maternal mortality in the United States from 58 cases per 10,000 live births in 1935 to 6 in 1953.

IN THE JOURNALS

Training Schools

A "fever" rather than a disease, juvenile delinquency has sources deep in the culture and morals of the community, writes Povl W. Toussieng, M.D., in the March 1961 quarterly issue of *Federal Probation*, and for that reason success with delinquent youth in correctional schools hinges largely on cooperation of the community, in turn a corollary of the community's understanding. ("The Role of the Psychiatric Consultant in a State Training School.")

The author, who is psychiatric consultant with a boys' industrial school in Kansas, comments on the rash of appointments of psychiatric consultants in training schools, sometimes made without adequate planning. He sets out guidelines for such schools' selection and use of psychiatric consultants, advising first that the school consider its goals. Is it reeducational? Then the consultant can contribute less—and the psychologist more—in setting up treatment targets and helping staff understand the child, than if "treatment" were the schools objective.

In the author's opinion, the psychiatric consultant could do more in schools with the clinical staff to translate technical advice into lay language for other workers. Also he asserts, psychiatrists of the psycho-analytic school, concerned with the interplay of many factors, are suited for schools with a multipronged treatment program rather than for those with a single rehabilitation approach. The psychiatrist in any case should be familiar with the community's subcultures as well as experienced in child psychiatry and juvenile delinquency, he maintains.

Seven Years of Fluoridation

Fluoridation of the water supply in Corvallis, Oreg., is credited with a sharp drop in the rate of dental caries among children there of 5 to 12 years of age, by investigators reporting in the April 1961 issue of *The Journal of Pediatrics*. ("Dental Caries Experience of School Children in Corvallis, Oregon, After 7 Years of Fluoridation of Water," by Gertrude Tank, D.D.S., and Clara A. Storvick, Ph. D.) At the time of the study, more than twice as many children in this age group were free from caries as before fluoridation. This effect was noted for teeth developed both before and after the fluorine content was raised.

The investigators point out that maximum effects on the children's teeth will not be apparent before 12 years of exposure to fluoridated water, but the beneficial results after only 7 years are highly significant.

Clinic-Centered Services

The practicality—in underdeveloped areas—of building child health services around a pediatric clinic rather than using the conventional, prevention-focused pattern used in the United States is described by Alfred Yankauer, M.D., in the March 1961 issue of *The Journal of Tropical Pediatrics and African Child Health*. ("Prospectus for a Child Health Service Built Around Pediatric Clinics.") The author, who is head of the Bureau of Maternal and Child Health of the New York State Department of Health, points out that the treatment-focused scheme recognizes conditions in countries such as India, with its shortage of medical manpower for treatment, let alone of preventive health services for children.

When he was in India as WHO visiting professor of child health at Madras Medical College, the author found that the mothers were strongly motivated to seek help only when their children were sick. This, coupled with the large number of acute episodes of illness among children there, make the personnel of a pediatric clinic ideally suited for health supervision and for introducing the family to the child health program, he says.

In presenting guidelines for a clinic-centered plan, the author advises having physicians and "health visitors" give health counseling at every opportunity—during medical examination and treatment, group meetings with mothers, at clinic or health center, and during home visits—thus making it the link for all activities.

Following a step-by-step account of the way such a program operates in India—from the mother's pregnancy through the child's first year—the article concludes with the observation that success lies in continuing assessment of whether program operations follow the original plan and in the willingness to modify the program if indicated.

Group Counseling

As a means of reaching a larger number of parents of its adolescent clientele without cutting into the time spent with these young people, a casework agency tried counseling parents in groups. This experience is reported in *Social Work* of April 1961 ("Group Counseling With Parents in an Agency Serving Adolescents," by Erwin M. Laibman). The author is a caseworker in the agency, the Youth Service of Cleveland, Ohio, which focuses on the emotional problems of adolescents.

Two groups of middle-income, suburban families, each group composed of parents of six adolescent clients, were selected on the basis of, among other criteria, relative family stability, and the absence of gross pathology. Brought together by such problems as parental control or the adolescents' school performance, disapproved choice of friends, or sexual interests, they met for an hour and a half each week, the first group six times and the second, eight. The parents also had individual interviews with the adolescents' caseworker.

The author tells about the way the groups were oriented to the group experience—with subjects such as the family structure or adolescent value systems—and gives highlights of group interaction. There were gains in arousing empathy and in unveiling fallacious thinking about teenagers. For example, most of the teenagers seen by the agency were misinformed or ignorant of sex facts rather than possessed of sophisticated accumulation of knowledge, as thought by the parents.

According to the caseworkers, the parents learned more about themselves and found relief from tensions in universalizing specific problems, the authors report.

READER'S EXCHANGE

RADINSKY: *What about the parent?*

Elizabeth K. Radinsky's paper entitled "Children of Discharged Mental Hospital Patients" [CHILDREN, May–June 1961] might leave the impression that the recent rise in discharge rates from mental hospitals has opened a virtual Pandora's box of complex problems for child-placing agencies. That staff members of agencies responsible for foster home placement of children would be concerned with the possible ill-effects of the return of their charges to parents who are former mental patients is understandable. Yet legitimate concern might be expressed, as well, for the discharged patient to whom the return of his children is denied.

Miss Radinsky states that ". . . for the child the parent is present whether or not he is on the scene. . . ." It is this writer's observation, based on experience with hospitalized psychiatric patients who are parents of young children, that for the parent, too, the child is present whether or not he is on the scene. If discharge of the patient can reasonably be anticipated, there seems to be merit in attempting to maintain the child's relationship with the ill parent during the period of hospitalization. Eugene A. Weinstein comments that for children in foster placement, "Regular contact with natural parents is a prerequisite for identification with them." ("The Self-Image of the Foster Child," Russell Sage Foundation, New York, 1960, page 51.) I have observed that when hospitalized patients are visited regularly by their children, the visits seem to be quite meaningful both to the child and the patient.

Perhaps the question to be posed is this: Do we want to bend every effort toward reuniting all family members once the patient is able to return home? If so, cooperative planning by the child-placing agency staff, the hospital staff, and family members is indicated. There should be no "closed ranks," with the patient excluded. Of course the nature of the patient's symptomatology, and the severity of the illness must be considered. But concerted effort and flexibility may increase the chances that children and parents can be reunited, to their mutual benefit, when the period of the parent's hospitalization is over.

Leila Calhoun Deasy
Associate professor of social research, National Catholic School of Social Service, Catholic University of America.

Author's response

If writing from the vantage point of the child-placing agency appears to be less empathetic with the discharged mental hospital patient than with his child, I want to thank Dr. Deasy for emphasizing the patient's need for his child. We have come to know well the meaning of child and parent to and for each other and so have come to a recognition and awareness of the limits of foster care in and of itself, even of foster family care. In our agency, these have been compelling factors in our constantly seeking ways of helping children and families to remain together or to be reunited as early as possible, the implications of which are borne out in the Weinstein study. Our intake studies and discharge plans attest to these efforts.

However, we cannot ignore the fact that 40 percent of our children in care show serious emotional problems and impaired personalities. Most of these children lived within seriously upset, malfunctioning families for protracted periods preceding placement. This in no way diminishes the advisability of maintaining contact with the parent. Whether contact should be maintained through visits of the child to the hospital or through an intermediary such as another parent or relative or, in the absence of these, the worker, has to be determined by the child's ability to cope with the shock of seeing his parent in a mental hospital setting, as well by the emotional state of both parent and child.

Dr. Deasy agrees that reunion of children with discharged mental patients has to be geared to the welfare of each and of both together. Premature discharge of a child needing special care may jeopardize the patient's recovery and the wholesome functioning of the family, as well as set back the child.

Rather than a "Pandora's box," we see the progress in treatment of the mentally ill as opening untold possibilities for the return of many children to their own homes and deterring total breakup of families. Protagonism for child *or* patient, however, can only defeat "family." Cooperative planning and mutual comprehension of the needs of the respective charges must be coupled with adequate services while the child and patient are in care and when they are together again as a family.

Elizabeth K. Radinsky
Director, Foster Home Division, Jewish Child Care Association, New York

CASE CONFERENCE: *A community failure*

I read the entire piece, "Case Conference" [CHILDREN, May–June 1961], through the eyes of a conservative and critical community fund donor and found myself squirming. I would be at a loss to explain, let alone defend, the situation as it unfolded in the case story.

To be sure, I would like to know more about the people in the family described, a lot more about the community, and I would like to hear what the social workers and doctors who knew the family have to say. However, even allowing for mitigating circumstances and understandable difficulties in providing the needed services, this family reflects a certain amount of failure on the part of the community. I was glad to see that the commentators did not duck that.

An obvious factor, of course, is the lack of coordination of effort and services. However, before coordination there must be a sense of *responsibility*—as the subtitle of the article ("Whose Responsibility?") clearly implies. The most shocking fact, however, is that no one in the community apparently felt any real responsibility for this family.

Recently the 15-year-old grandson of

a friend of mine was attacked in a Connecticut town by a group of older boys, and so seriously injured that he spent 2 weeks in the hospital and may still require major surgery. The question is whether any *one person* or any one group in that town will have enough righteous indignation and "umph" to do anything about the conditions that produced such behavior.

Coordination of services does not start, will not work, and cannot last unless it emerges from, operates under, and is sustained by a strong sense of responsibility expressed by *individual* citizens. The community which was the setting of the case story obviously needs a reawakening of its sense of responsibility. It makes little difference who sounds the challenge, provided he has the respect of his fellows. Once the call has been sounded, the men and women who have community organization skills and a sound philosophy can help to guide developments.

The basic need in both this and the Connecticut community is for a few people of character to care enough to arouse themselves and others out of their complacency. No amount of bright community "schemes" can take the place of an aroused citizenry in getting an agency started, keeping agencies in team play, and (with the help of good professional skill) keeping long-range planning in operation.

Sometimes one "good failure" such as the one described can start a chain reaction of improvement, if it is put to good use and is handled well.

Leonard W. Mayo
Executive Director, Association for the Aid of Crippled Children, New York

COHN: *A lesson from abroad*

Helen Cohn's article describing the coordinated well-child and pediatric services provided by the American Joint Distribution Committee in Teheran is evidence that when the pieces of a service are well put together, the whole is greater than the sum of parts. ["A Family Health Program in Teheran," CHILDREN, May–June 1961.] Moreover, the gains achieved are great when the frontline staff-workers (in this case the behyars or public health nursing assistants) know where to go and what to do when they get there.

My experience with public health nursing service in maternal and child health programs in the United States has led me to believe that we do not yet have good enough definitions of the correct composition of caseload, nor clear enough definitions as to what the public health nurse must do when she makes a home visit or sees her patients in the clinic or health center.

William M. Schmidt, M.D.
Head, Department of Maternal and Child Health, Harvard School of Public Health

MECUM: *A different approach*

As an administrator in another Eastern State school for delinquent girls, I am impressed by the apparent differences in educational and sociological backgrounds of the girls in our school and those in the State school described by Ethel D. Mecum in the March–April issue of CHILDREN. ["Bringing Training School and Community Together."] Differences in problems and opportunities are inherent in the location of the schools, one "in a small city in a small State," the other—ours—located within the capital city (population 114,167) of a State with a population of 6,039,594 concentrated in urban areas. Most of our girls come from the urban areas.

Because of these basic differences in the two schools, our approach to the public relations program and the integration of the school with the community is necessarily different. Each institution has to tackle these problems on the basis of staff, clientele, geographical assets, and limitations, as well as availability of resources, both in terms of leadership and agencies.

Miss Mecum's article spells out clearly ways in which volunteers can enrich the program of the institutions by carrying continuing leadership roles both with groups and with individuals. The question which I would like to ask is: approximately how many man-hours of staff time were allocated to work with volunteers and for community contacts? Experience has shown that unless sufficient staff time is available for training the volunteers, and for a continuing relationship of staff with them, the program is doomed to failure.

Our volunteers come from all over the State. Approximately 25 come once a week or twice a month, and in addition we have an average of 80 each month working with and for the girls in a variety of projects. The latter are generally different individuals each month who, we hope, will interpret the institution and its program positively. They come from church groups, service clubs, fraternal organizations, labor unions, and some group work agencies. Materially they have contributed gifts both large and small.

For example, in July of 1955, Sub-Junior clubs of the State Federation of Women's Clubs composed of high school girls, began coming to the institution in groups on Saturday afternoons to meet with our girls. The Sub-Junior clubs came from all parts of the State and such groups made only one or two visits during the year. For our girls it was a continuous program of service projects with which they assisted the Sub-Juniors, interspersed with parties or entertainments. The interest of the Sub-Juniors gained momentum and culminated 4 years later in the raising of $35,000 by the total junior membership department of the federation to build a playfield at the institution. Staff as well as girls have enjoyed the contacts this project afforded.

Such contacts and gifts have improved our program within the institution. However, we have only scratched the surface. The opportunities brought to the girls while in the institution may develop self-confidence, new interests, skills, and leadership qualities, but back in their local communities they may not have these opportunities. Will this then be another frustration for them, another disillusionment?

Are we in the institutional field plugging enough for the establishment of community agencies to work with the teenager before he or she becomes a delinquent? Are we who see the results of lack of parental love and supervision, the lack of early detection of personality problems, lack of organized recreation in communities, sharing our information with citizens groups? Are we helping not only to make possible opportunities for young people committed to the training schools, but also for those still uncommitted but in need?

Helen Sheley
Superintendent, New Jersey State Home for Girls, Trenton

Photo Credit

Frontispiece, Richard Keller, Philadelphia United Fund.

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A SELECTED BIBLIOGRAPHY ON PHENYLKETONURIA. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 27 pp. Single copies are available free of charge from the Bureau.

The first listing by the Children's Bureau of selected literature on phenylketonuria, this bibliography is divided into sections devoted to testing and detection, surveys of population groups, and biochemical and genetic aspects, among others. Under each title is a distillation of the work's principal points. An index of authors is also included.

DOMESTIC AGRICULTURAL MIGRANTS IN THE UNITED STATES; counties estimated to have 100 or more at peak of normal crop season. Revised. Department of Health, Education, and Welfare, Public Health Service; Social Security Administration, Children's Bureau; and Department of Labor, Bureau of Employment Security. PHS Publication No. 540. 1960. Copies are available without charge from the Public Health Service, the Children's Bureau, and the Bureau of Employment Security, as well as from State health departments and employment security agencies.

As an aid for agencies concerned with domestic migration, this map identifies by variations in shading the degrees of domestic migrant concentration by county or groups of counties throughout the United States.

STUDY OF STAFF LOSSES IN CHILD WELFARE AND FAMILY SERVICE AGENCIES. William B. Tollen. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960. 193 pp. 55 cents.

Through a detailed analysis of data assembled by the Children's Bureau with the cooperation of voluntary and State welfare agencies, this report answers questions on professional staff losses in family and child welfare agencies, of interest to agency executives, directors of schools of social work, and social workers. Differences in rates of turnover among the different categories of age, marital status, and training background; reasons for these workers' resignations; and what they did subsequently are discussed.

YOUR CHILDREN AND THEIR GANGS. Edith G. Neisser and Nina Ridenour. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 384. 1960. 34 pp. 20 cents.

With emphasis on the need of almost every child for participation intimately in a group of his own, this booklet discusses the meaning of these groups, the forms they may take, and the group "code." The publication also outlines constructive ways for parents to help the group and the child.

CHILDREN WHO RECEIVE SERVICES FROM PUBLIC CHILD WELFARE AGENCIES. Helen R. Jeter. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 387. 1960. 60 pp. 25 cents.

Presents facts and figures on the number of children receiving child welfare services from public welfare agencies, the results of the first of such studies since 1945. Data include the characteristics—age, sex, color, living arrangements, marital status of parent—of 220,812 children in 45 States receiving such services.

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children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Unemployed Youth

Youth Workers and Police

Minimal Brain Damage

Studies of Illegitimacy

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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◀

A PRICKED FINGER provides the blood sample for determining whether this little Iranian girl has any malaria parasite in her blood. Supplies for the anti-malaria campaign now being carried on by the Iranian Government with technical assistance from the World Health Organization have been furnished by the United Nations Children's Fund (UNICEF). Broadened plans for the types of aid UNICEF, now completing its 15th year, will make available to underdeveloped countries are described on page 191.

James Bryant Conant, scientist, educator, and diplomat, who recently completed a study of the American high school and junior high school, has now embarked on a study of the education of American teachers, sponsored by the Carnegie Corporation. One-time president of Harvard University, Dr. Conant has been chairman of the National Defense Research Committee, a member of the General Advisory Committee of the Atomic Energy Commission, and Ambassador to Germany.

Before coming to the Children's Bureau 6 years ago, Mary E. Blake was for 10 years director of the Eliot Park Neighborhood House in Minneapolis. Previously she was field secretary for the American Service Institute at Pittsburgh, an organization concerned with the integration of the ethnic groups in the community life. She has also worked with youth serving organizations in Cleveland.

A 1942 graduate of the University of Pittsburgh School of Applied Social Sciences, Howard McClary has worked in settlement houses in Pittsburgh, Minneapolis, and Lawrence, N.Y., and has been fieldwork supervisor for the Pittsburgh school, the New York School of Social Work, and the University of Minnesota School of Social Work. He has been with the Baden Street Settlement since 1958.

Raymond L. Clemmens, long an advocate of the multidisciplinary approach in the assessment and management of handicapped children, has taught pediatrics at the University of Maryland School of Medicine since 1954, and directed its diagnostic clinic for children with multiple handicaps since 1958. He is physician at St. Francis School for Special Education and Lutheran Hospital, Baltimore.

Hannah M. Adams came to the Children's Bureau in the spring of 1960 from the National Board of the YWCA where she was director of data and statistics. She was for many years on the research staff of the United Community Services of Boston. She received her social work training from the University of Chicago School of Social Service Administration and the Simmons College School of Social Work.

Organizational behavior and criminology have been the focus of interest for Marston M. McCluggage, a sociologist who applies behavioral science concepts in analyzing concrete interpersonal and administrative problems. He has been in his present post since 1938 and has also taught in the Universities of Missouri, Washington, and Rhode Island.

◀ *the authors*

National Advisers to CHILDREN:

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SOCIAL DYNAMITE IN OUR LARGE CITIES

JAMES B. CONANT

President Emeritus, Harvard University

THE EXISTENCE in the slums of our large cities of thousands of youth ages 16–21 who are both out of school and out of work is an explosive situation. It is social dynamite.

In preparation for the recent Conference on Unemployed Out-of-School Youth in Urban Areas, a few special studies were conducted in slum areas of large cities to find out what the facts really were. In a slum section composed almost entirely of Negroes in one of our largest cities, the following situation was found. A total of 59 percent of the male youth between the ages of 16 and 21 were out of school and unemployed. They were roaming the streets. Of the boys who graduated from high school, 48 percent were unemployed in contrast to 63 percent of the boys who had dropped out of school. In short, two-thirds of the male dropouts did not have jobs, and about half of the high school graduates did not have jobs. In such a situation, a pupil may well ask why bother to stay in school when graduation for half the boys opens onto a dead-end street?

An even worse state of affairs was found in another special study in a different city. In a slum area of 125,000 people, mostly Negro, a sampling of the youth population showed that roughly 70 percent of the boys and girls ages 16–21 were out of school and unemployed. When one stops to consider that the total population in this district is equal to that of a good-sized independent city, the magnitude of the problem is appalling and the challenge to our society is clear.

Today the fate of freedom in the world hangs very much in balance. Our success against the spread of communism in no small measure depends upon the successful operation of our own free society. To my mind, there is no question that a healthy body politic necessitates a sound economy and high employment. The history of communism shows that it feeds upon discontented, frustrated, unemployed people. The present unemployment rate, nationwide, is roughly 7 percent for all age brackets, but unemployment among youth under 20 years of age is about 17 percent, or more than twice the rate for all workers. These young people are my chief concern, especially when they are pocketed together in large numbers within the confines of the big-city slums. What can words like "freedom," "liberty," and "equality of opportunity" mean to these young people? With what kind of zeal and dedication can we expect them to withstand the relentless pressures of communism?

A youth who has dropped out of school and never has had a full-time job is not likely to become a constructive citizen of his community. Quite the contrary. As a frustrated individual he is likely to be antisocial and rebellious. He may end as a juvenile delinquent. No one would claim that providing full employment for youth in the large cities would auto-

This article is a condensation of a paper presented by the author at the Conference on Unemployed Out-of-School Youth in Urban Areas, held in Washington in late May under the auspices of the National Committee on Children and Youth. The material in it is taken largely from the author's latest book, "Slum and Suburbs: A Commentary on Schools in Metropolitan Areas." (McGraw Hill, New York, 1961.)

matically banish juvenile delinquency, for we all realize that the causes of this probem are complex and there is no one solution. However, I suggest that full employment would have a high salutary effect. Moreover, I offer the following hypothesis for professional social workers and sociologists to demolish: that the correlation between desirable social attitudes (including attitudes of youth) and job opportunities is far higher than between the former and housing conditions.

Consider for a moment the long-run consequence of the persistent failure of underprivileged youth to find work. Leaving aside the human tragedies involved in each individual instance and looking at the matter solely in terms of the welfare of our free society, one sees the special position of the large-city slums. Three factors are significant: first, the total size of the group of youth to whom I am referring—the larger the group, the more dangerous; second, the density of the population—the number of frustrated youth per block; third, the degree of isolation of the inhabitants from other kinds of people and other sorts of streets and houses.

Youth in the Slums

The youth in the big-city slums dwells in the midst of a mammoth social complex. The surrounding city extends for blocks and blocks. The business and industrial areas hem in the impoverished youth. In the case of the Negro, added to all the negative influences of a slum is the absence of any evidence that there is a pathway out. In spite of the high mobility of the family unit or perhaps because of it, a tone is set by constant talk and the prevailing attitude of the older people. And the tone is not one to encourage education or stimulate ambition. The unemployed floaters on the street are evidence to all the youth that nothing can be accomplished through education, that the door of the neighborhood schoolhouse indeed opens on a dead-end street.

In my opinion, there is no reason why this should be the case. I know there are those who maintain that, on the average, Negro children are inferior to white children in academic ability. I have seen no evidence to support any such contention. In considering the relative abilities of white and Negroes, let us examine the situation in an all-white slum in a city of considerable size. A careful study of a group of children in grade 4 of one such school showed that their average achievement level was a full year below their grade placement—a typical situation in any slum area.

What the teachers in this school have to contend with is shown by a report from the principal.

> When a residential area composed of large, old homes formerly occupied by owners and single-family groups changes, economically and socially, conditions of general deterioration begin. Absentee owners rent the property by single rooms or small so-called apartments of two or three rooms to large families. . . . Such conditions attract transients (who either cannot or will not qualify for supervised low-income housing), the unemployed, the unskilled and unschooled, and the distressed families whose breadwinners have either just been committed to prison or mental institutions or who have but recently been released from such. The only possession most of these families have is children. . . . In such an environment all forms of evil flourish—the peddling of dope, drunkenness, disease, accidents, truancies, physical, mental and moral handicaps, sex perversions involving children. . . .
>
> The parents of at least one-third of the children are either in penal institutions, or on probation, or have prison records. At least 100 children are on probation to the juvenile court. There has not been a day since I've been at the school that there has not been one or more children in detention at the juvenile court. . . .
>
> Unless a school is able to educate its children so they may become competent and responsible citizens, its work is a temporary stopgap that relieves immediate suffering only. Although the school is the only organization that has instruction as its primary responsibility, when a noble-hearted teacher faces a barefoot, hungry, sick, distressed child, the result is an endless chain of efforts to relieve such a child.
>
> We realize that little or nothing can be done for or with the parents of the children who face such serious problems in their homes. These problems directly affect the child's health, attendance, emotional and personal adjustment, his learning and his progress (or lack of it) in every respect. In all probability at least one-half of our children will be school dropouts. In our opinion the children need desperately, for desirable development, in addition to good schools—good homes, churches, and communities.

This official report in acknowledging the generally low achievement of the white children in this school, makes the interesting statement:

> There is no reason to believe that these students as a group are inherently or genetically less capable than average students, but apparently because of some types of experiences in their lives they have been unable to develop their intellectual skills.

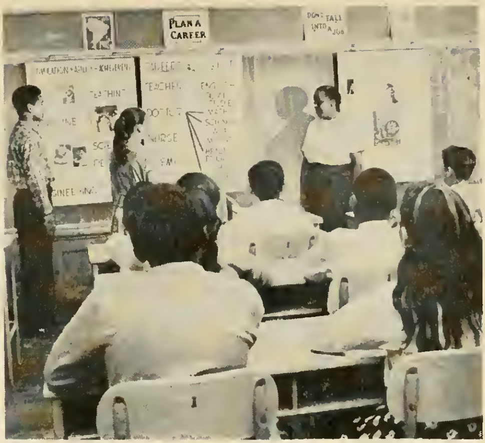
The belief expressed in the first part of this sentence can hardly be based on anything firmer than an assumption as to the genetic uniformity of white children whose ancestors have for several generations lived in the United States. Such an assumption, of course, leaves out of account the possibility of a selective process occurring over the generations as some tended to move to one type of occupation and settle in one type of community. However, since I see no way of investigating the role of selective migration, I should be inclined to let the assumption stand unchallenged. *Only I would argue strongly that to date we have no evidence to indicate that the assumption should not be broadened to include both white and Negro students.*

All the contrary evidence, namely the poor work in school and low scores on tests made by Negroes, is based to a large degree on the performance of children in what are essentially slum conditions. Consequently, I start with the belief that, given a satisfactory socioeconomic background and educational opportunity, Negro children can be just as successful in academic work as any other group. Dramatic success has been achieved in more than one instance in raising the aspirations and achievement levels of slum children.

A Racial Problem

True, big cities have always had slums. In the United States it has been possible for people to raise themselves by their own bootstraps in the course of a generation. Why be alarmed about the present situation? First and foremost is the fact that in the past most of the inhabitants of slums were recently arrived white foreign immigrants. They knew that their predecessors for generations had worked their way out of poverty in the cities. They were convinced that they could do likewise. The almost complete lack of such conviction—a consequence of the tragic story of the Negro in the United States—is the outstanding characteristic of youth in the Negro slum. Secondly, a foreign immigrant came from an impoverished but stable society, for the most part a peasant society with its own ancient mores. The pride of family and often strong church connections were social cement that kept the slums from being complete jungles. Lastly, labor shortages rather than labor surpluses were characteristic. Particularly, unskilled laborers were in demand. When this was not so, as in the depression years, organized society had to step in on a large scale to bolster up the tottering social structure. Today, automation has affected the whole employment scene; there is much less demand for unskilled labor. Racial discrimination makes unemployment chronic for the Negro male North and South.

In short, neither in terms of the kinds of people involved nor in terms of the economic and social setting is there much resemblance between the slum districts of 1900 and those which are the sore spots of our modern cities.



Young people in the Higher Horizons project of the New York City school system learning about preparation for a career. Goal of the project is to motivate promising young people from culturally deprived environments to learning, by providing increased pupil personnel, guidance services, field trips, other cultural opportunities, and work with parents.

What was especially shocking to me in my visits to the large cities in the last school year was the discovery that the employment of youth is literally nobody's affair. To be sure, there are groups concerned with various aspects of the problem, but no single agency in any of the cities has the data as to the unemployment picture in that city. There is little up-to-date information about youth unemployment, even citywide, and only the estimate of school people about the slum neighborhoods. Seldom are figures available to distinguish between the unemployed who are high school graduates and those who have dropped out of school before completing the 12th grade. Most important, it is not possible to say with any accuracy how the unemployed youth are distributed among various neighborhoods and among various minority groups.

The problem of unemployed youth in the large cities is in no small part a Negro problem. We do not facilitate its solution by trying to find phrases to hide this fact. And it is largely a Negro problem in the North because of the discrimination practiced quietly but extensively by employers and labor unions. In an effort to overcome this unjust and nationally dangerous discrimination, people must not shrink from publishing statistics, unpleasant as they may be. How can we improve a situation if we are deprived of knowledge of what the situation really is?

I should like to explain how I became concerned about the social problems of the big city. The subject of my first report, *The American High School Today*, was the widely comprehensive high school found in independent cities that were not part of a large metropolitan complex. However, in conjunction with my study last year of junior high school education, I decided to take a more detailed look at schools in metropolitan areas—at schools in slums and suburbs.

In the large metropolitan areas of New York, Philadelphia, Detroit, Chicago, St. Louis, one has no difficulty in locating examples of both. In some cases a 20-minute drive will enable a person to go from one to the other. A visit to the high school serving each community will open the eyes of a visitor to the complexities of American public education. Their basic problems are quite unlike, and these differences spring from the differences in the nature of the families being served.

One lesson to be drawn from visiting a well-to-do suburb and a slum is all important for understanding American public education: to a considerable degree what a school should do and can do is determined by the status and ambitions of the families within the community. I drew this conclusion after either my staff or I had visited metropolitan schools in and around many of the largest cities in the Nation—New York, Los Angeles, Chicago, Detroit, Philadelphia, Baltimore, and St. Louis.

A group of young people registering at the Youth Office of the U.S. Employment Service's District of Columbia office. For such services the hard-to-place youth is the young person with neither vocational training nor a high school education.

Contrast in Suburbia

In the suburban high school from which 80 percent or more of the graduates enter some sort of college, the problems are the reverse of those in the city slums, where as many as half the students drop out of school prior to graduation. The task with which the school people must struggle in the city slum is, on the one hand, how to prepare the youth for getting and keeping a job as soon as he or she leaves school and, on the other hand, to encourage those who have academic talent to aim at a profession through higher education. The task thus stated seems simple. In fact, the difficulties are enormous. I am not nearly so concerned about the plight of the suburban parents whose offspring are at present having difficulty finding places in prestige colleges as I am about the plight of parents in the slums whose children drop out of school or graduate without prospects of employment. The latter is a much more serious social phenomenon, and too little attention has been paid to it.

Visits to a wealthy suburb and impoverished slums only a few minutes away jolt one's notions of the meaning of equality of opportunity. On the one hand there is likely to be a spacious, modern school staffed by as many as 70 professionals for 1,000 pupils; on the other hand, one finds a crowded, often dilapidated and unattractive school staffed by fewer than 40 professionals for 1,000 pupils. Expenditure per pupil in the wealthy suburban school may be as high as $1,000; it is less than half that in the slum school. To my mind, in view of the problems one finds, conditions in the slum school necessitate more staff and more money than in the suburban school.

Leaving aside the suburban communities, I should like now to point up some of my observations in the slums of the large cities we visited. In each of these cities, one can find neighborhoods composed of various minority groups. Many of these are areas now designated as "culturally deprived" or "culturally different," but in my youth they would have been more simply designated as "slums." The schools serving such neighborhoods have to be visited in order for one to understand the nature of the tasks which the teachers face.

The slum areas of certain big northern cities are today largely inhabited by Negroes who have recently moved from the South hoping to improve their lot. The economic changes in the South which have forced this migration are well known. The Negro is being displaced as a farm laborer, and, being unable because of discrimination to obtain other employment in the section where he was born, he becomes a migrant headed North. St. Louis is said to be the first stopping point for many who make the journey, though the school people in Chicago, Detroit, Philadelphia, Baltimore, Washington, or New York indicate that their problems with the recently arrived Negroes from the South are quite as great as those which confront their colleagues in St. Louis.

The building up of a mass of unemployed and frustrated Negro youth in congested areas of a city is a social phenomenon that may be compared to the piling up of flammable material in an empty building in a city block. Potentialities for trouble—indeed, possibilities of disaster—are surely there.

Let me describe a slum that might be in any one of several of the large cities I have visited. The inhabitants are all Negroes and with few exceptions have entered the city from a State in the Deep South anywhere from the last month to the last 3 years. Often the composition of a grade alters so rapidly that a teacher finds at the end of a school year that she is teaching only a few of the pupils who started with her in the fall. In one school, I recall the principal stating that a teacher absent more than 1 week will have difficulty recognizing her class when she returns. The mothers move with their offspring from room to room from month to month, and in so doing often go from one elementary school district to another; I am told that resident tenements look more like transient hotels.

I write "mothers" advisedly, since in one neighborhood, by no means the worst I have seen, a questionnaire sent out by the school authorities indicated that about a third of the pupils came from family units which had no father, stepfather, or male guardian. Less than 1 percent of the parents had graduated from college; only 10 percent of the parents had graduated from high school; only 33 percent had completed elementary school; and another 32 percent did not go that far.

These Negro slums seem to vary considerably as regards the social mores. In some there are very bad gangs, with gang warfare, among the boys. There are also vicious fights outside of school between girls. The condition in one such neighborhood was summed up to one of my staff by a principal of a junior high school who said even he was shocked by the answers to a questionnaire to the girls which asked what their biggest problem was. The majority replied to the effect that their biggest problem was getting from the street into their apartment without being molested in the hallway of the tenement. This principal went on to say that the area had a set of social customs of its own. The streets are full of unemployed men who hang around and prey on the girls. The women are the centers of the family and as a rule are extremely loyal to the children. The men, on the other hand, are floaters.

Problems for School

In some cities, New York in particular, there are also slum areas inhabited largely by recent arrivals from Puerto Rico. In these sections, the problems are similar to those I have described, but complicated by the difference in language. One hardly needs to point out that this adds one more complication to the tasks confronting the administrators and teachers in New York City schools. Add to these tasks the possibilities of interracial hostility and gang warfare between Negroes and Puerto Ricans and the resentment of both toward the whites and one has a veritable witches' brew which comes to boil with unsavory vehemence in certain schools in certain areas—particularly among young people of junior high school age.

One needs only to visit the type of school in a big-city slum to be convinced that the nature of the community largely determines what goes on in the school. For example, I have walked through school corridors in slum areas and, looking into classrooms, have seen children asleep with their heads on their hands. Is this situation the result of poor teachers without either disciplinary control or teaching ability? No; the children asleep at their desks have been up all night with no place to sleep or else have been subject to unbelievable family fights and horrors through the night.

A principal told one of my staff that, checking into one case, after climbing six flights of a tenement he found the boy's home—one filthy room with a bed, a light bulb, and a sink. In the room lived the boy's mother and her four children. I might add that it is not unusual for teachers in these schools to take home with them children with little or no place to go at night. It is after visits to schools like these that I grow impatient with both critics and defenders of public education who ignore the realities of school situations to engage in fruitless debate about educational philosophy, purposes, and the like.

As one teacher in a slum neighborhood said to me, "We do quite well with these children in the lower grades. Each of us is, for the few hours of the schoolday, an acceptable substitute for the mother. But when they reach about 10, 11, or 12 years of age, we lose them. At that time the 'street' takes over. In terms of schoolwork, progress ceases; indeed, many pupils begin to go backward in their studies!"

What Can Be Done?

What can be done to offset the demoralizing attitude of "the street" in the worst of the slums? Not much that lies within the province of the school authorities alone. Here is where the social agencies, the juvenile courts, and the churches must come into the picture.

There are clearly many areas of concern. Among the more important are racial discrimination; employment practices of labor and management; Federal-State laws, involving insurance rates and wage scales; lack of jobs, as well as changing types of employment because of automation and the necessity for more highly skilled workers; the role of the schools in preparing youth for employment, especially average and below average youth, and in helping them make the transition from school to work; the coordination of the efforts of the schools, the employers and labor unions, and the various community agencies that have a hand in promoting youth welfare; and the role of the public sector of the economy at the local, State, and Federal level in providing employment if the private sector of the economy is unable to do so. All of these questions are complex and controversial.

There are those who would say that what goes on in the schools should not have any direct connection with the community or the employment situation. I completely reject this idea. The school, the community, and the employment situation are and should be closely tied together. I am not impressed by the holding power of a school as a criterion of its quality, but neither am I impressed by the argument that a boy who fails to get along in school ought to drop out. It all depends. The situation in which a boy drops out of school only to roam the streets is quite different from the situation in which a boy drops out and finds satisfactory employment. Full-time schooling for certain youths through grade 12 may be good or bad, depending upon the employment picture. What goes on in the school ought to be conditioned in large measure by the nature of the families being served, the vocational plans and aspirations of the students, and employment opportunities.

I submit that in a heavily urbanized and industrialized free society, the educational experience of youths should fit their subsequent employment. This should be so whether a boy drops out of school in grade 10, after graduation from high school, or after graduation from college or university. In any case, there should be a smooth transition from full-time schooling to a full-time job.

This is an ideal situation admittedly and one which is at present approached only in the learned professions and in a few instances in the occupations for which undergraduate college courses provide the necessary training. In the case of the learned professions, those in charge of the last stage in the educational journal—the professors of law, of medicine, and those who direct the research of candidates for the Ph. D.—have usually a sense of responsibility for their students based on their own passionate interest in promoting the best interests of their profession. Graduates of some undergraduate professional courses in some institutions are also often assisted in finding employment.

When we examine the situation at the high school level, we find quite a different state of affairs. Although in many high schools a half or more of the graduates seek employment immediately on graduation, only in a few cities does one find an effective placement service. And I make this statement without intending any reproach to either social agencies or to guidance counselors. The obligations of the school should not end when the student either drops out of school or graduates. At that point the cumulative record folder concerning a student's educational career is usually brought to an end. It should not be. To my mind, *guidance officers, especially in the large cities, ought to be given the responsibility for following the post-high-school careers of youth from the time they leave school until they are 21 years of age.*

Since compulsory attendance usually ends at age 16, this means responsibility for the guidance of youth ages 16 to 21 who are out of school and either employed or unemployed. It is with the unemployed out-of-school youth that I am especially concerned—especially the boys, for whom the unemployment problem is more severe than for girls. This expansion of the school's function will cost money and will mean additional staff—at least a doubling of the guidance staff in most of the large cities; but the expense is necessary, for vocational and educational guidance must be a continuing process to help assure a smooth transition from school to the world of work. The present abrupt break between the two is unfortunate. What I have in mind suggests, of course, a much closer relationship than now exists between school, employers, and labor unions, as well as social agencies and employment offices.

Unfinished Business

There is no question that the school people in the large cities face a gigantic task in their efforts to prepare youth from impoverished homes for useful lives as responsible citizens and productive workers. I have the heartiest respect for the dedicated men and women who with limited means and facilities are doing the best job they can to overcome the adverse influence of the home and street in the big-city slum. As one of my associates who had spent the best years of his life as principal of a suburban public high school put it, "I visited junior high schools in New York City in some of the worst areas. I expected to find blackboard jungles; instead I found schools with high morale, tight discipline, and imaginative principals and teachers." In my own visits I found similar schools in Chicago, Detroit, and St. Louis, and my admiration for what is being done in those cities is equal to that of my colleague for what he saw in New York City.

But all problems have not been solved. Far from it. Reading is the essential tool for success in school and on the job, and although in this area much has been done, much remains to be done, particularly with respect to gaining the interest of the parents in the success of their children, reducing class size, and providing for more remedial reading teachers. Decentralized administration in the big cities is surely a step in the right direction by bringing the schools closer to the people. A new look is needed at vocational programs, especially for the below-average students who are rejected by the vocational people and academic people alike.

Many of the large cities have made attempts to prepare slow learners for work. These efforts and adult education courses, work-study programs of various sorts are all evidence of a continuing interest of the schools in furthering educational opportunities for out-of-school youth and ought to be expanded.

But much remains to be done for the future dropout to ease the break between school and job. It appears that the only jobs available for unskilled workers in the decade ahead will be in service occupations, a fact of considerable importance in educational planning.

Finally, an important obstacle in improving the education of slum children is the fact that teachers who may have taught in schools for a number of years with a certain kind of student body suddenly find themselves engulfed by slum children whom they do not understand and for whom they fail to recognize the need for changes in the curriculum. In many cases, a reeducation of the teachers becomes necessary.

In short, there is much that schools are doing, but much more that they should do. Money in many instances is the key—remedial reading teachers, smaller classes, and guidance counselors cost money. I have already noted the vast disproportion between the amount spent per pupil in the wealthy suburbs and that spent in the slums of the big city.

But even if the schools were to improve their services drastically, there would still remain what seems to me the crux of the situation—the presence or absence of employment opportunity. Whereas I have indicated my conviction that the problems of Negro education are no different from those of all underprivileged socioeconomic groups, the problems of Negro employment are distinctly different. The enforcement of antidiscrimination laws has proved a most difficult undertaking. It is generally agreed that only those projects which are supported by public funds can really be operated on a truly nondiscriminatory basis. Therefore, because of the urgency of the situation, I think it is necessary for Congress to appropriate funds for public work programs to alleviate unemployment among youth 16 to 21 in the large cities. I estimate that roughly 300,000 jobs are needed.

In conclusion, let me repeat my sense of shock as I contemplate conditions in our big cities with respect to youth in slum neighborhoods. To improve the work of the slum schools requires an improvement in the lives of the families who inhabit these slums, but without a drastic change in the employment prospects for urban Negro youth, relatively little can be accomplished. I urge that our large-city problems be analyzed in far more detail than in the past and with a far greater degree of frankness. Neighborhood by neighborhood we need to know the facts, and when these facts indicate a dangerous social situation, the American people should be prepared to take drastic measures before it is too late.

YOUTH WORKERS AND THE POLICE

MARY E. BLAKE

Group Work and Community Services Consultant, Division of Juvenile Delinquency Services, Children's Bureau

BUILDING satisfactory interprofessional working relationships is never easy, and, when two such disparate groups as police officers and social group workers attempt to work together, the difficulties are multiplied. In the past decade in most of our large cities some social agencies have moved into new services that reach out to serve groups of hostile, aggressive, sometimes delinquent young people who roam the streets arousing public concern. In doing so the agencies have been faced with the necessity of finding ways to improve the working relationships between youth workers and law enforcement personnel.

By definition a relationship connotes a connection, but historically social workers and police, and their respective agencies, have had few connections. In too many places the contacts they have had with each other have been infrequent, casual, or unsatisfactory. Basic differences in the functions and operating philosophies of the parent agencies have affected the quality of these connections. Underlying these differences has been a mutual ignorance of each other's duties and responsibilities, considerable distrust, and some fears.

This situation might have indefinitely remained the status quo had police and youth workers not been confronted with daily reminders that they had to find ways of working together effectively on behalf of troublesome, delinquent youth. Actually they have pushed their parent agencies into an examination of background facts and urged them to set up new designs for improved interagency collaboration.

What is the nature of these daily reminders? Consider this incident as related by Officer X:

> I was on patrol duty last night when I saw a gang of kids in leather jackets congregated at a corner. We have had reports of intimidation of children and adults, and even some gang fights in this area recently, so I was on the alert for possible trouble. I walked over to this bunch of kids and told them to "break it up" and move on. One of them shouted that they weren't doing anything wrong, they were only waiting for their youth worker to take them for a ride. The others joined in saying they had a right to be on the street and dared me to do anything about it. Other people began to crowd around watching. Just then a big station wagon drew up at the curb, empty except for the young guy who was driving. He yelled, "Hop in" and the kids piled into the car. As he pulled away they laughed and yelled, "Copper, what ya gonna do now? Try and get us!" I was sure that station wagon and those kids didn't belong together legally, so I reported the incident at precinct headquarters. The captain said he'd heard about a community center hiring a youth worker to meet with street clubs in the area. He said maybe the kids were telling the truth, but we'd have to wait and see. But I know those kids—where they are there's trouble.

Now, what does the youth worker have to say about the same event? His record reads like this:

> The Texans were waiting at the corner for me to take them to a ball game. Not one was absent! They were all talking at once and it was hard to quiet them down enough to make plans for getting together again after the game in case we became separated in the crowd, and I gathered from their talk that they had had an argument with a policeman because they were upset and calling him names. I didn't have a chance to get the details until we were on the way home. Then I learned that club members had been standing on the corner waiting for me when the officer tried to break them up and get them to move on. They hadn't been making any trouble. Why should they have to move on? They have the same rights as everybody, but they are always being criticized. I admit that they deserve most of the criticism, but they've got to build confidence in themselves and get credit for trying to do better, if they are ever to face up to the meaning of their behavior.

This incident is mild compared to those involving gang fights, the carrying of lethal weapons, or the use of drugs. But it exemplifies the poor connections between law enforcement personnel and social worker and the frustrations they encounter.

Today in a number of communities, individual social agencies and in some places groups of agencies are taking steps to develop better working relationships with local police departments. A beginning at systematizing their experiences on a nationwide basis has also been made, through two national conferences: the National Conference on Youth Groups in Conflict, held in 1957 under the sponsorship of the Children's Bureau in cooperation with the National Association of Social Workers, the National Social Welfare Assembly, and United Community Funds and Councils of America; and a small working conference of police and youth workers called by the Children's Bureau early in 1960.

On the basis of these conferences and other information gathered by the Children's Bureau, a broad picture of the nature of the problem begins to emerge. It shows that sponsorship of services to street clubs and youth gangs is concentrated in voluntary agencies that have had few traditional connections with law enforcement agencies. The major exceptions to this pattern are in Los Angeles, New York City, and Washington, D.C. But even in these places, relationships between youth workers and police have not always developed easily.

Most voluntary agencies with reaching-out programs established them without fully realizing their implications for other organizations, especially those with authority conferred by law for maintaining the peace and protecting the community. Some of their public counterparts made similar mistakes.

From an analysis of accumulated experience, it is possible now to define some of the sources of these relationship difficulties. One is mutual misunderstanding of the functions of law enforcement and service organizations and of the methods each uses to fulfill them.

A police department has the legal authority and responsibility for maintaining the peace and enforcing the law. Its officers are required to investigate, apprehend, and bring to the attention of prosecuting officials persons who have violated the law. In addition, they perform regulatory duties such as directing traffic and inspecting various kinds of facilities for compliance with the law. This range of functions, coupled with the necessity for making judgments and taking responsible action in the midst of crises and public tensions, requires them to function under great pressure.

The youth worker's major function is to try to reduce the antisocial behavior of members of street clubs by helping them to develop constructive attitudes toward the law, by encouraging them to assume responsibility for their behavior, and by redirecting their activities. Operating in high delinquency areas they serve young people who are nonconforming, suspicious of all authority, and aggressively determined to test all adults. These young people attract trouble like a magnet attracts steel. Thus, the youth worker also functions under pressure and in the midst of crises.

Police and youth workers actually have common goals in promoting the general welfare and protecting society. Why should they encounter difficulties in finding ways of working together?

The answer to this question is many-sided. One side reflects the image each worker has of the other. Another side is the result of the public's images of them. Still another side is related to the methods each uses in his work.

Casual observation of what a youth worker does with his group can lead to mistaken conclusions: He is soft; he lets youth go too far; he overprotects them; he has teamed up with them in opposition to law and order.

But the activities of a police officer are also subject to casually made misconceptions: He is tough; he has no regard for civil rights; he is more interested in punishing people than he is in protecting them.

These faulty images derive from ignorance and prejudice. Perhaps the best way to correct them is to improve communications. Surely Officer X should have been informed that the community center had initiated service to a street club in his area. His precinct captain should have been given complete information about the new program, and an oppor-

This meeting of a New York City Youth Board worker, policeman, and a club of teenage boys was arranged by the youth worker to discuss minor incidents of vandalism which had occurred in the housing project where many of the boys lived.

tunity to introduce the officer to the youth worker. But now feelings are ruffled, status is jeopardized, and repairing the damages of mistakes takes precedence over major mutual objectives.

Some Suggestions

In order to promote common understanding and reduce friction, some of the agencies that have "gone through the mill" have drawn up some guidelines for planning reaching-out services. These fall into three categories.

The first category presents some axioms for the initiators of services to street clubs:

- Electing to serve street clubs and youth gangs propels a social agency into the total effort to reduce crime and delinquency and to rehabilitate offenders.
- An effective attack on juvenile delinquency requires collaboration with personnel at all levels in official and nonofficial organizations.
- Responsibilities and duties of official agencies are prescribed by law. Failure to discharge them carries serious consequences for the individual employee and his agency.
- Governmental agencies operate under legal principles that permit few if any deviations from specified procedures. Freedom to adapt procedures or to operate independently exists only when and if the law and its administrators permit the exercise of discretion.
- Productive joint effort has to be built on mutual sharing of pertinent information, open discussion of the philosophies underlying agency methods, and clear statements about agreed-upon operating procedures.
- Social agencies, as relative newcomers to an avowed commitment to prevent delinquency, should take the initiative in alerting police agencies to their plans and in seeking their counsel.

The second category suggests methods for opening up communication channels and developing procedural agreements:

- Top level officials in local governments, police departments, and the involved social agencies should meet together to review the problem.
- They should each draw up a clear statement of the functions and responsibilities of their respective organizations.
- They should draw up and distribute agreed-upon procedures for handling misunderstandings that are apt to arise within their own organizations and between individual representatives from any of the agencies involved.

While the persons who benefit most from written statements are those who participate in developing them, the existence of such tangible evidences of agreement provides a framework within which personnel at other levels can develop detailed procedures.

The third category suggests methods for implementing these agreements:

- All personnel in the involved organizations should receive copies of written statements and be given opportunities to discuss how they pertain to operations.
- Joint discussions of the statements between police officers and youth workers in the neighborhoods should be arranged for.
- Opportunities for frequent informal contacts between individual police officers and youth workers should be encouraged.
- Some means of easy identification of youth workers should be provided in order to prevent misunderstandings.

Law Violations

To the uninitiated such a solid foundation might seem inevitably to lead to sound working relationships. But experience does not justify this assumption. The knottiest problems crop up when youth workers and police officers are faced with a crisis in which they must make quick decisions.

One of the most complicated problems is that of defining the youth worker's responsibility for reporting infractions of the law to the police. The determination of what violations must be reported and the procedures the youth worker should follow in reporting them presents the greatest difficulties. Although details in resolving these issues differ from city to city, consensus exists on a few major points:

- Youth workers are responsible for upholding the law and for reporting known violations to the police.
- They should have working knowledge of pertinent State laws and city ordinances such as the juvenile court code, and should know what constitutes misdemeanors and felonies.
- They should be skilled in helping young people to understand and accept the law, and should serve as models for their group members in this respect.

Thus, the youth worker never consciously violates a law himself nor does he condone others in doing so. He is instructed by his agency to report all major offenses about which he has firsthand knowledge. For example, he must report incidents involving the possession, use, or sale of narcotics; possession or use of lethal weapons; impending or actual gang fights; and other acts endangering persons or property.

The worker is usually expected to tell the group about this obligation at the beginning of his service, though the timing of the explanation varies with local conditions. It then becomes a consideration in the group's accepting or rejecting him as its street club worker.

In essence, the workers say to the group: "I know you are in trouble, and that's why I'm here. I like you and believe that you really want to live on the side of the law. Let's work at this together. But, let me warn you now, if you break the law you will have to take the consequences. My agency and I will intercede for you whenever we can, but we won't overlook or condone law violations. We will have to report them."

The candor of such an approach must have considerable appeal because it rarely prevents the boys from accepting the worker's offer of help. However, numerous tests of the worker's commitment to this stand arise in the course of service. Youth workers need support in meeting these tests and in making their responsibilities clear to their group members. They also need help in determining the difference between a real violation and fictional bragging.

A youth worker operates in a "no man's land" where opposing factions imagine his actions to be in conformity with their images of him. The police may see him as a part-time police officer, an informer, or an assistant investigator—or they may regard him as a conspiratorial protector of troublemakers. His group members may see him as a "stool pigeon," a preacher, or a "con man." All of these faulty images can become obstacles to the achievement of the worker's central objective—bridging the gulf between his group and law-abiding society. A wrong decision on his part may destroy his effectiveness with the group and with the police department.

Because of these difficulties social agencies which provide services to street clubs have devised supportive aids to guide youth workers in making decisions concerning their own conduct and the handling of interagency agreements. The keystone of these supports is the youth worker's supervisor, most effectively an experienced social worker with professional maturity, broad knowledge of the community, and tested skill in community relations. The supervisor and the youth worker meet regularly to discuss written reports of group meetings, individual contacts, and other information gathered by the youth worker. Together, they appraise the youth worker's accomplishments and determine what his next steps should be. The supervisor is also accessible to the youth worker in an emergency.

Because of a widespread misunderstanding of the common law concept of misprision, it is sometimes asserted that all citizens, including social workers, have a duty to report all known offenses to the police. This is not true. Misprision in this country is accepted in the law only in New Jersey and is related only to felonies, never to misdemeanors. The reporting of felonies and misdemeanors by youth workers is an asset to police work which would not otherwise be available. Rigid insistence on reporting all misdemeanors would go far beyond what is necessary to assure adequate community protection.

However, in the course of regular conferences or during emergency consultations, a decision may be reached that the police should be informed about a violation that has come to the youth worker's attention. Ordinarily the supervisor makes this report to the police department indicating that the youth worker is available for further discussion and amplification if necessary.

Such procedures lead to an orderly handling of reports by reducing the numbers of social agency staff who initiate such contacts with police. They also discourage any tendency the police may have to think of youth workers as sources of kinds of information they cannot supply. In many instances they have resulted in the police department's designating one police officer, or two or three at the most, to act as liaison with social agencies. If a police department has a juvenile specialist unit, officers from this section usually carry this responsibility. This enhances the quality of communication and furthers the development of productive working relationships between the youth serving agencies and the police. It sometimes leads to informal agreements that permit flexibility in dealing with youth in conflict with the law.

Quick Decisions

Satisfactory as these arrangements may be, the road to effective working relationships is not yet completely smooth. Some of the rough spots are due to ineffective interpretation of procedures to personnel working in the neighborhood. Others can be traced to the fears and misapprehensions of patrol officers and youth workers on the street corner.

If rival gangs are on the verge of a street fight, the youth worker and the patrol officer on duty at the moment are the social agency and police representatives who must work together. The success or failure of their collaboration at this point forecasts their future effectiveness in handling other incidents. Thus, they too need to develop mutual trust and confidence.

Suppose late one night a youth worker detects a suspicious bulge in the hip pocket of a member of his group. He immediately wonders: Is the boy carrying an illegal knife or a gun? Either eventuality would be a major offense. Naturally, the worker first confirms or refutes his suspicions. If he finds that the boy is actually carrying a forbidden knife, his next step is a decisive factor in determining his future effectiveness.

Suppose now that this boy has never before been involved in a serious delinquent act. The youth worker knows that the boy is amenable to calm persuasion and that he generally reacts negatively to sharp commands. The worker also knows that the boy has low status in the group, particularly among the boys who have histories of previous offenses and who wield considerable influence on the group.

The worker takes the boy aside, explains the dangers and the consequences of this violation of the law, and outlines the courses open to him. He urges the boy to turn over the weapon voluntarily to the police, promising to accompany him and the patrolman to the police station and speak on his behalf. But the boy is afraid to do this and offers to relinquish the weapon to the worker with the promise that he will not repeat the offense.

Should the worker accept the knife? Having it in his own hands insures the present safety of the community, thus achieving one of his objectives. The other objective, that of helping the boy to understand himself and to improve his ability to be a law-abiding person, may be jeopardized if succeeding events are not skillfully handled.

Because of the lateness of the hour, the worker's supervisor cannot be consulted. The worker must handle this alone and deal directly with the police officer on duty.

According to the procedures set up between his agency and the police department, the worker has no choice about reporting the incident. But can he give the boy any assurance that his case will receive understanding attention rather than routine processing? What will happen to the worker himself if he is apprehended while the knife is in his care? Actually he has no authority to have it in his possession even long enough to take it to his agency or the police station.

The youth worker's hesitation stems from his knowledge that there have been similar occasions when workers have been arrested and charged with illegal possession of a weapon. He also knows of instances in which, in spite of police assurances that the offender's previous good record and his acquiescence in relinquishing the weapon would be taken into account, these factors were apparently disregarded in the disposition of the case.

Quick decisions are part of the worker's daily job. His sense of responsibility for following agency procedures and for protecting the community looms larger than the risk to a single relationship. So he takes the knife, explaining that he has to report the violation and that he stands ready to help the boy handle the consequences; and inwardly he hopes that the patrolman on duty and the officer at the police station are ones he already knows fairly well.

Mutual trust and confidence are best achieved in face-to-face contacts divorced from the tensions of crises. Therefore, it is important that police departments and social agencies promote opportunities for informal discussions between line officers and youth workers. The foundation laid by the agreements on procedures reached between the high-level officials of both organizations protect their respective employees from going beyond their functions and authority in these informal meetings.

In one eastern city where service to street clubs is coordinated by a single, citywide voluntary agency, a variety of experiments are underway for improving orientation programs and inservice training of police officers and youth workers. Here the local police training institute has called upon the coordinator of the special youth program to serve as lecturer in several courses. Police officers participate in meetings held for group supervision of all youth workers. Police also participate in training programs for youth workers through lectures and by arranging for youth workers to observe officers in action at precinct stations, on the beat, and in squad cars.

A midwestern city is now planning a joint training program for youth workers and police officers in which the focus will be on information about the institutional systems within which each works, the sanctions that govern their actions, and the limitations of their authority. And in another midwestern community a local college has provided an extension course for youth workers, police, and representatives of other organizations concerned with unlawful youth. Here too, the focus was on what each type of worker needed to know about the others' programs and problems. Out of this course came vastly improved working relationships.

Such efforts give substance to the hope that the day may come when hostile, alienated youth can feel confident that the adult community is offering a responsive, consistent, but firm hand to guide them to law-abiding citizenship.

VOLUNTEER AIDS FOR PROBLEM-RIDDEN FAMILIES

HOWARD C. McCLARY
Executive Director, Baden Street Settlement, Rochester, N.Y.

DURING THE PAST decade or more, a number of studies in several cities of the United States have shown that a relatively small number of families with a multitude of problems require a disproportionate amount of social and health services.[1,2,3] These include families repeatedly facing emergencies which prevent them from functioning at anywhere near their full potential, as well as families tending to be regularly or intermittently dependent financially. If a father is present in the home, he is most often unskilled, illiterate, or possessed of only a minimal formal education. Frequently he is disabled because of accidents or ill health. Mothers often have a history of unwanted pregnancies, within and outside of wedlock, and show evidence of poor housekeeping and faulty home management. There may be also patterns of adult and juvenile delinquency, emotional disturbance, and mental illness among members of the family. A variety of social and health agencies may have been contacted by these families to assist with crises, then dropped by the families once the emergencies subsided. Such families are described by social agencies as "hard-to-reach," "hardcore," and "multiproblem."

One of the many social agencies attempting to reach and help such families is the Baden Street Settlement in Rochester, N.Y. Located in a deteriorated area adjacent to the heart of the city, the settlement attempts to meet the neighbors' pressing needs through group work and through nursery, health, and casework services as well as through referral to other community facilities.

In 1952, the settlement set up a consultation department with a small staff of professionally trained workers. Soon after the development of this department, its staff became overburdened with families referred from other departments of the settlement and other agencies, and with a large volume of direct appeals for help from families who lived in the neighborhood. There was little time left for the staff to work toward forestalling crises and perhaps improving conditions for these families. The settlement was led, therefore, to seek other ways of operating to include such preventive functions.

While the staff was looking for a new method of helping these families, people in the general community were especially disposed at that time to give their volunteer services in other than the usual jobs as clerical assistants, nurses' aids, teachers' assistants, and club leaders. Stimulated by local churches, which encouraged increased participation in social endeavors, these people wanted to be more personally identified with the work of social agencies.

Case Aid Demonstration

Putting these ingredients together, the settlement's executive director, staff, and board of directors developed a pilot project in 1956 to test the use of agency-trained volunteer case aids as family visitors. Three churches were approached and 12 individuals recruited. Following two 2-hour orientation and training sessions, 10 volunteers (4 men and 6 women) with considerable volunteer and educational background were each assigned a family to visit every week or two. Prior to every visit a supervisory conference was held with a professionally trained caseworker. Recording was required of all case aids.

After 6 months of experimentation, the settlement staff was convinced that the results achieved by the pilot project justified its expansion into a more extensive demonstration. The expanded project would show the community that hard-to-reach families could be helped through the use of carefully screened and agency trained and supervised volunteers. The Junior League of Rochester, which had previously shown interest in such projects, was approached in the fall of 1956 and agreed to supply financial, advisory, and volunteer support for a 2-year demonstration period. The sum of $7,000, provided by the league, permitted the halftime employment by the settlement of a professionally trained caseworker for 2 years to supervise volunteer case aids.

The goal of reaching out to hard-to-reach families was achieved then, in a new and unique way—through volunteers. The decision to use volunteers was made not only for budgetary reasons and because of the short supply of professionally trained workers, but also for more positive reasons. It had been the experience of the settlement staff that normally, hard-to-reach families with many problems responded slowly and frequently had difficulty in relating positively to professionally trained social workers. The staff hoped to find that such families would respond to a less formal, less demanding relationship, and could benefit from regular visits by volunteers, carefully selected, trained, and supervised. The staff also hoped that with sufficient interpretation and encouragement from the volunteers, the families would make more effective use of the various services available to them within the settlement and within the wider community.

The volunteer case aids were not to be expected to carry out the functions of the trained caseworker. They would not be required to exceed the limits of help which could be given by intelligent, sympathetic, and understanding friends, but they would have the advantage over the normal friend of being informed about the family with background data and of being given regular technical help and supervision by a professionally trained worker. The trained worker would know the client through the volunteer, through the settlement's accumulated information about the family, or through data from other agencies.

Demonstration Methods

In April 1957, the demonstration was initiated with four volunteers from the pilot project and six new recruits.

In selecting the volunteer case aids, the following questions were considered:

- Can the applicant accept cultural and social standards different from his own?
- Can he face objectively and with understanding the problems of low-income families?
- Does he feel that the time required can be spared from his family and other personal obligations?
- Does the applicant's spouse approve of this service?
- Can the motivation which impelled the applicant to volunteer be utilized constructively within the program?
- Does the applicant recognize that while there may be positive aspects to volunteering in the program, there will also be some that are negative?

No commitments were made to use any volunteers in the program, nor were volunteers required to commit themselves to it, until after the completion of orientation and training (now expanded to three 2-hour sessions) and a followup interview with the case aid supervisor, sometimes referred to as the program supervisor. The first 6 new recruits were assigned families in June 1957 and the program continued to expand until a maximum of 18 volunteers were working in it at one time and regularly visiting 20 families. Ordinarily, a recruit was assigned a single family, but two volunteers each had two related families assigned to them.

Families selected included those having one or more of the following characteristics:

- The need of substantial and significant support and services from social welfare resources, especially public agencies;
- Long-range and chronic problems;
- Behavior which was antisocial, disruptive, or a threat to welfare of the general community;
- Failure or inability to use voluntary services, lack of interest in them, or the family members' failure to recognize the existence of a problem.

These families were selected from a number that came to the settlement only at times of great emergency or maintained contact only through a peripheral interest of one or two members of the family. The settlement's help in these cases had not been directly related to the family's most severe problems. There were also families who had been referred to the settlement from other agencies that did not accept the help offered and were known to continue to need help. The records of the families proposed for the program were first reviewed by the program supervisor and then cleared with the social service exchange. The decision of which family would be assigned to which volunteer was based upon the judgment of the program supervisor. Volunteers with experience in working with people were assigned families from which resistance was anticipated.

After compiling a case history and formulating a tentative diagnostic hypothesis, the program supervisor met with the case aid to help him understand the situation in the home and family problems and needs, to define what help a family seemed ready to accept, and to work out methods of helping the family to meet its needs. For example, the P family, consisting of a mother and nine children, was referred to the case aid program by a city agency which was attempting to find the family better housing. The agency's staff believed that the family could not be relocated until the mother's housekeeping practices were improved. Prior to assigning a case aid to the family, the program supervisor learned that the mother, who had had many of her children out of wedlock, had failed to keep clinic appointments and made no attempt to use nursery and group work services. The supervisor believed that the family would most readily accept help first in regard to their housing problem and that the case aid could impress the mother with the need to improve her housekeeping practices in order to secure improved housing. Helping in other areas could follow after a helping relationship was established around the housing problem.

Additional conferences focused on helping the case aid to remain as objective as possible about the family's needs, teaching him about the settlement's resources and services, keeping him aware of and working toward the achievement of modest goals, and helping him evaluate the job he was doing. For example, in the case of the P family, a series of goals was established, each succeeding goal being dependent upon the accomplishment of the earlier one—(1) improved housekeeping practices, (2) improved housing, (3) conferences with other interested agencies to involve them in a plan to help the mother meet her difficulties in rearing nine children, (4) temporary placement of six of the children outside the home, (5) a teaching homemaker in the home, (6) return of the temporarily placed children as the mother became ready for it. Still other goals were established as the family became better known to the case aid and his program supervisor.

Records were kept by the case aid, and a supervisory conference was scheduled with the program supervisor after every visit to the assigned family.

Soon after home visits were started, the case aid explained to the family his relationship to the settlement and to the program supervisor. The family was referred to the supervisor at some time, and also to some other of the settlement's programs. In almost every case the program supervisor provided direct service to families when they appeared to have trouble accepting a service or doing something about a problem or wanted additional help which the case aid could not give. For example, in instances of serious marital conflicts the program supervisor usually dealt with the family herself, either by providing direct counseling or referring the family to a casework agency or another appropriate service.

The program supervisor also acted directly when a referral to another agency was under consideration; when problems involving personality difficulties or family relationships came to the fore; or whenever intense feelings were a factor. This direct service was usually provided at the settlement rather than in the family home. The program supervisor also handled collateral contacts with other settlement staff workers and outside agencies, and participated in recruiting and training case aids and interpreting the program to the community.

Results and Findings

A total of 155 crises or precrises were referred to the program supervisor during the period of February 1957 to March 1959. These included evictions, financial emergencies, health problems, marital difficulties, neglect of children, unemployment, legal questions and involvement, juvenile delinquency, child spacing needs or housekeeping problems. Such difficulties confronted 31 families who were assisted by a total of 25 case aids. It was the judgment of the program supervisor and settlement staff that, with the help of case aids, 59 of these problems had been successfully worked through and limited success had been achieved in 67, while the service provided in 29 cases had been unsuccessful in achieving its goal.

If a specific problem was solved and did not recur during the study period—an eviction stayed, improved housing obtained, full-time employment secured, school adjustment problems removed—"total success" was adjudged. If there was movement from unemployment to part-time or seasonal employment, if housekeeping practices improved but were still below standard, if truancies or unauthorized absences from school were reduced but not eliminated, "limited success" was assumed. If there was no evidence of progress toward a particular goal during the study period, "failure" was ascribed.

During these 2 years, 9 families in the program made more regular use of the settlement's health center services; 17, of the agency's group work services; 6, of the nursery; and 4 of the consultation department's services. In addition, a total of 63 referrals were made by the settlement to 20 social, health, and other agencies.

As a result of referrals and other contacts by the supervisor with other agencies, 8 families were helped to forestall evictions or to find other housing; 7 families had their housing improved by their landlords; 12 families were helped with marital problems; and 15 families were provided with material aid, such as clothing and furniture.

Case aids succeeded in establishing friendly, supportive relationships in all but two families. In these two, extreme emotional disturbance was subsequently discovered, and professional workers were assigned to the families. In general, considerable improvement was achieved in communications between social and other agencies and the families assigned to the case aids. Also improved was the coordination among the settlement's services.

Apparently, the case aids found this experience satisfying and meaningful since, between February 1957 and March 1959, only 2 (of 26) volunteers left the program because of personal dissatisfaction with their roles. On several occasions these volunteers joined the staff in telling community groups and interested individuals about the program. In this, they proved excellent interpreters. They also assisted the board of directors and executive director in winning financial support for the program.

Additional funds were provided by the Junior League of Rochester and the Women's Educational and Industrial Union to permit continuation of the volunteer case aid program on a part-time basis through August 1959. In the meantime, foundation funds to expand the program were sought unsuccessfully by the settlement. As a last resort an appeal was made to the Community Chest of Rochester and Monroe County. This appeal was successful and as of September 1959 the case aid supervisor was employed full time and more volunteers were recruited. Within the 7-month period of September 1959 through March 1960, the program was expanded to include 35 families, each with a case aid.

In Conclusion

The Baden Street Settlement staff and the social agencies that referred families to the settlement are convinced that sufficient improvement in the families' circumstances has occurred to warrant continuation of the program.

An analysis of the work accomplished on the project in this period indicated that an average of 67½ hours per week was spent by the program supervisor and volunteer case aids in direct contact with 35 families or in working in their behalf through collateral contacts, recording, or supervisory conferences. It also led to these conclusions:

- The one worker one family relationship in the volunteer case aid program permitted the case aid and program supervisor to provide more immediate help to the families in emergencies or crises than would have been possible had all the families been assigned to one trained worker without case aid assistance.
- The volunteer case aids help to overcome resistance on the part of some families to accepting help from a social agency in solving some of their problems—resistance sometimes built up by difficult experiences with social agencies in the past.
- The families in the program gave indications to their case aids and the supervisors that they felt they were wanted. Their self-respect seemed to be increased by knowing that the help they were receiving was being given voluntarily by a person concerned only with their own care and no other.
- Since the "hard-to-reach" families living in the neighborhood of the Baden Street Settlement understood the settlement's services better than the services of more distant community resources, the case aid program tried and succeeded frequently in introducing them to the types of help that other organizations could give, bringing families and community resources into communication with each other.
- In providing weekly contacts with families that are in danger of developing major problems, or that have already developed them, the program also provided the program supervisor and other workers with useful insight into ways of averting crises.
- The use of volunteers from the wider community improved communication and understanding between at least some families of the neighborhood and others in the wider community, making clearer in human terms the problems and strengths of problem-ridden families and the relation of their problems to the attitudes and practices in the whole community.

There are many areas within which supportive relationships to problem-ridden families are important. The lack of help in such areas or its provision only through professional help could be extremely costly to the community. There are some families in the community that will require supportive help for extensive periods, if they are not to become even greater problems to themselves and their community. This supportive help can be provided by volunteer case aids who are regularly and carefully supervised by a professionally trained caseworker.

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[1] Bradley Buell & Associates: Community planning for human services, Columbia University Press, New York, 1952.

[2] Birt, Charles J.: Family centered project of St. Paul. *Social Work*, October 1956.

[3] Geismar, L. L.; Ayres, Beverly: Families in trouble. Family Centered Project, St. Paul, Minn., 1958.

An interdisciplinary problem, medical, paramedical, and educational . . .

MINIMAL BRAIN DAMAGE IN CHILDREN

RAYMOND L. CLEMMENS, M.D.

Director, Child Evaluation Clinic, Department of Pediatrics, University of Maryland School of Medicine

MANY PROCESSES, both environmental and biological, contribute to an individual's overall development. It is generally accepted that in the child who is without intellectual deficit, most deviations in behavior and performance are determined primarily by psychocultural factors. Less emphasis is apt to be placed on the importance of the integrity of the central nervous system through which behavior and learning are mediated and monitored.

In our clinic, a multidiscipline diagnostic clinic for handicapped children, operated by the University of Maryland in Baltimore, and the Maryland State Department of Health, we have evaluated 525 patients and have encountered a surprisingly high number—19 percent of the total group—in whom, after exhaustive examination and assessment, the final diagnosis was minimal cerebral dysfunction or minimal brain damage without intellectual subnormality.

This clinic population is not by any means a representative segment of handicapped children, but is a highly selected group of children referred to the clinic from various places throughout the State of Maryland over a 3-year period. It seems likely, however, that other pediatricians have encountered youngsters with the same perplexing problems.

The subject of minimal brain damage involves considerable controversy as to whether or not this is a diagnosable clinical entity. The dispute is not unexpected, however, for several reasons:

1. The subject matter deals with inherently complex functions which are difficult to measure.
2. The clinical techniques available to assess brain function are relatively crude and, in general, not designed to elicit subtle deviations in higher cerebral performance.
3. In an era in which the importance of environmental stresses in the causation of abnormal activity has been emphasized strongly, it has become somewhat unfashionable to diagnose organic cerebral pathology in the absence of specific neurological signs.

General Considerations

The brain is an organ of enormous complexity, some of the more delicate functions of which are not readily assessable by the usual neurological examination. Among these functions are perception, cognition, judgment, concentration, impulse control, visual and auditory memory, perceptual motor function, and symbol organization. Injury to or maldevelopment of the cerebrum may interfere with these higher brain functions and contribute to certain behavioral deviations, language disorders, and learning disabilities in the absence of specific neurological signs of mental retardation.

When cerebral dysfunction exists and the clinical neurological examination is normal, the term "minimal brain damage" or "minimal cerebral dysfunc-

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Based on a paper presented at the 1961 spring meeting of the American Academy of Pediatrics.

tion" is used in designation. The conduct disturbances associated with minimal brain damage are termed "organic behavior disorders." The language problems and learning disabilities that are related to neurological impairment are classified as neuropsychiatric learning disorders.

The clinical manifestations of this kind of neurological deficit vary with the age of the patient and severity and location of the abnormality. Such disorders may not be apparent in infancy. Not uncommonly they present themselves as developmental deviations in the preschool years. Most frequently such disturbances are first noted in the early school years. Characteristically, adjustment and academic problems occur between the ages of 5 and 11 years.

As components of a continuum, behavior disorders and neuropsychiatric learning disabilities caused by minimal brain damage usually exist together in varying combinations, though they may occasionally appear independently. Characteristic of this impairment is absence of specific neurological signs, although minor degrees of motor incoordination, nonspecific awkwardness, mixed laterality, time and spatial disorientation, or adiadochokinesis (inability to perform rapid alternating movements) can usually be detected. Delayed speech development, mechanical speech imperfections, echolalia (meaningless repetition of others' words), strabismus, visuo-motor impairment, and abnormal electroencephalograms are found in greater numbers than in control subjects.

Organic Behavior Disorders

It has long been known that persistent disturbances in personality may be noted in a child who has suffered epidemic influenzal encephalitis or severe head injury.[1,2] Behavioral deviations similar to those associated with postencephalitic and posttraumatic states are also found in children in whom no convincing evidence of cerebral insult can be elicited. Frequently noted in the histories of these children are maternal pregnancy complications, prematurity, and perinatal difficulties.[3]

The borderline between that which is normally active behavior and that which is pathological is not easy to define. In extreme cases, however, if familiarity with the pathological condition has been established, the difference may be recognized without difficulty.

There are no pathognomic signs for minimal organic impairment of the central nervous system, but it is possible to describe in general terms those characteristics which are frequently noted in children with such impairment and to point out trends which suggest neurological impairment, based on objective but inferential observations. Similar characteristics are at times noted in children who are healthy and normal. However, when they occur in greater frequency, with greater severity, and in combination, and persist through the various stages of development, they can be regarded as related to cerebral dysfunction.

Hyperkinesis (hyperactivity) and distractibility are the two most striking features of organic behavior disorders. The child is constantly in motion. More important, however, than the degree of hyperactivity, is the quality of his overall performance. Because of excess distractibility he cannot ignore the countless inconsequential visual and auditory stimuli which the normal child selectively screens out. As his interest and attention are directed first to one object and then to another with little design or apparent intent, his overall demeanor may assume a bizarre character—disorganized, disruptive, and unpredictable. Cohen[4] described this kind of childhood activity in detail over 20 years ago and used the term "organic driven-ness" to denote the apparent surplus of inner compulsions.

Whatever its causation, this non-goal-directed, semivolitional, seemingly irrational deviation from normal patterns is extremely difficult for others to tolerate. The child's classroom adjustment is apt to present a major problem. The task of learning becomes extraordinarily difficult, due, at least partially, to restlessness and the inability to exclude irrelevant sensory impressions.

Impulsiveness, perseveration, emotional lability, lowered frustration tolerance, inappropriate and sometimes overwhelming anxiety further contribute to the child's anomalous adjustment.

It was Strauss[5-7] who first presented a systematized approach to the psychological assessment of the brain-injured child and stressed the disturbances in perceptual and conceptual functions. He pointed out the importance of the differential diagnosis to determine whether a youngster with bizarre behavior is neurotic, psychotic, brain-injured, or mentally retarded.

Additional and important contributions to our understanding of children with these perplexing symptoms have been made more recently by Bradley,[8] Eisenberg,[9] Laufer,[10] Rogers,[11] Knobloch,[12] Bender,[13] and others in this country, and Luria[14] in the U.S.S.R.

It was Pasamanick[3] who first presented convincing evidence of the high incidence of pregnancy and perinatal complications in the histories of hyperkinetic children. He postulated that certain organic behavior disorders are reproductive casualties related to cerebral palsy, epilepsy, and mental retardation.

One of the conspicuous characteristics of the child with subclinical neurological impairment is the manner in which he relates to people. This may take one of two extremes: an inappropriate and unselective display of affection to total strangers; or a pronounced and continued disregard of people, similar to the responses of patients with early infantile autism, whose regard for individuals is not unlike their regard for furniture.

However strong the observer's organic orientation might be, he will find it difficult to ignore the strikingly high incidence of psychopathology in the families of these children, although this is not a universal phenomenon among them. While neurological dysfunction, from whatever cause, contributes to only a small fraction of all conduct disturbances in children, in brain-damaged children there seems to exist a lowered emotional threshold as a result of cerebral disorganization and thereby a predisposition to embarrassment by environmental stresses—stresses under which the non-brain-injured child might manifest no compromise.

Eisenberg[9] in his classical paper on the psychiatric implications of minimal brain injury has stressed the psychobiological background of this syndrome and its expression as a physiological disorganization of adaptive behavior.

Cohn[15] has referred to the syndrome as "social dyspraxia," a splintered, apparently aimless, searching demeanor which is other than merely a reaction to environmental stresses.

Importance of Diagnosis

Differential diagnosis in the child who may be neurotic, schizophrenic, autistic, or brain-injured is of more than academic importance. The usual psychotherapeutic approaches may need modification to assist the child with cerebral dysfunction effectively. Parent counseling, with the object of helping the parent understand why this child has been so hard to rear, might be carried out in a significantly different manner than with parents of a child whose basic difficulty was emotional disturbance.

In the assessment and management of the disturbed parent-child relationship, either as cause or effect of the child's disorder, it seems pertinent to recognize whether the child's environmental needs are excessive because of neurological disturbance. Parents who would be well-equipped to satisfy the needs of a healthy normal child may be incapable of meeting the requirements of a child who is brain-injured, so that the child is left in a state of relative environmental deprivation. For, the needs of the brain-injured child are excessive: for understanding, acceptance, affection, guidance, and well-directed, consistent, firm, and early discipline.

Although the organic background of hyperkinetic behavior seems certain, the point of view that this is not amenable to psychological therapeutic intervention cannot be justified. Organic drives can be modified by environmental influences although this may be a difficult undertaking.[16]

Drug therapy has been of significant value in decreasing the hyperactivity, distractibility, and extreme anxiety associated with brain injury. Many pharmacologic agents have been used. Encouraging and at times dramatic results have been obtained with dextro-amphetamine, benadryl, and, notably, dilantin.

If secondary emotional complications have been avoided, the long-term outlook of the hyperkinetic child with adequate intellectual endowment is favorable. As he matures, the child often develops the ability to compensate for perceptual distortions. In most such children, hyperactivity and impulsivity can be expected to show significant resolution shortly after puberty, either with or without medication.

Learning Disorders

The language and learning disorders associated with cerebral dysfunction cannot be ascribed merely to shortened attention span and poor classroom adjustment. They represent specific disabilities which are ralted to high cortical functions.[17,18] As such they are extremely difficult to diagnose.

It is well known that the schools contain many children who seem destined to be educational casualties—bright children whose school life is burdened because of inordinate difficulty in mastering the basic academic skills. A characteristic of most of these children is delayed acquisition of reading ability. They may also have a similar difficulty with arithmetic, spelling, and writing. If the child is a nonreader, he eventually encounters difficulty in all academic processes which require comprehension of written language. The usual presenting complaint is overall academic deficiency.

Often when the ordinary investigations reveal no apparent physical cause for such learning difficulties and when psychological testing indicates average ability or better, these children are categorized as lazy, poorly motivated, or emotionally blocked.

In the most severe cases, their disabilities may derive from:

1. **Auditory agnosia,** a condition in which sound is received by the brain, but not interpreted, and so has no meaning attached.
2. **Motor aphasia,** in which there is interference with ability to express a meaning in language.
3. **Dyslexia,** in which there is impairment of the reception, integration, and utilization of visual symbols, and so, an inability to read.[19]

The milder forms of psychoneurological learning disorders may be manifested only as inconsistent auditory comprehension, mild articulation defects or difficulties in word finding, or slight delay in the acquistion of reading skills.

Failure to recognize the neurological background of these problems may lead to serious psychic trauma, to which the child is already predisposed because of a coexisting lowered emotional threshold. The constant, and seemingly inevitable, day-to-day failures these children experience produce feelings of inadequacy and eventually lead to anxiety, hostility, rebellion, and schoolphobia, thus further aggravating their unsatisfactory school adjustment and academic achievement.

It is unlikely that all, or even most, specific language and learning disorders are due to tissue injury. The high incidence of such disabilities in the families of children presenting these difficulties[20] and the predominance of males among them suggests the possibility of a genetic inheritance in a significant number. This has evoked the concept of cerebral dysmaturation—or developmental deviation—not related to native intelligence, but involving specific centers or pathways of the brain.[21] However, the exact location and nature of these defects has not been described.

It is necessary to recognize that the constellation of behavior and learning disorders described here represents highly specific if often ill-defined disabilities. They constitute only a small percentage of all adjustment and academic problems among children.

Children with the symptoms described here appeared in our clinic and were studied conscientiously by competent professional workers for many months before a gradual awareness of the complex psychobiological background of these disorders evolved.

A Interdisciplinary Problem

Out of our study and experience we have arrived at the following observations:

1. Some educators, neurologists, psychologists, and audiologists have been aware of the significance and importance of minimal brain dysfunction for many years.[22]
2. The inherently complex nature of the problems of children with this disability crosses many professional boundaries, but the professional workers have not learned to complement each other effectively in their efforts to help. They have not cultivated the interprofessional communications and exchange of ideas which are necessary for our mutual understanding of these complex problems.
3. Many children, the nature of whose handicaps are not well understood, are being treated in child guidance clinics, remedial reading centers, speech correction classes, and special educational settings, although they have never been adequately studied and have not responded well to long-term and intensive intervention.[23,24]
4. Brain-damaged children are being treated for schizophrenia or autism and presumed environmental deprivation without consideration of the fact that their detailed developmental history often reveals that they were never healthy, normally responsive children even in earliest infancy.
5. Speech therapists are treating children for mechanical speech defects when, in some instances, a profound central language disorder exists.
6. Known bright children with specific reading disabilities have been managed for long periods of time on the presumption that they were poorly motivated, emotionally blocked, or neglected at home.
7. Intelligent children with reading disabilities are being considered mentally retarded on the basis of group intelligence tests which presuppose the one skill which is notably impaired.
8. Hyperactive children have been excluded from schools as antisocial without recognition of the nature of their handicaps and without provision of appropriate educational facilities and techniques to meet their special needs.
9. The usual neurological examination is sensitive to less than 50 percent of brain function, yet many clinicians have excluded the possibility of any central nervous system pathology on the basis of this type of examination alone.

10. The skills and techniques of the clinical psychologist, audiologist, and speech pathologist may detect neurological impairment in the absence of classical neurological signs.[25]

11. The electroencephalogram can be expected to yield significantly valuable information about central nervous system function even in the absence of clinical seizures. It is abnormal in over 50 percent of children with hyperkinetic behavior, specific reading disabilities, and language problems.[26-28]

The current controversy over the implications of minimal cerebral dysfunction does not promise to be resolved in the foreseeable future. The full significance of this type of impairment is not yet known and must await the time when the medical, paramedical, and educational disciplines have learned to communicate with and complement each other.

The author acknowledges the cooperative efforts of the following staff members of the University of Maryland's diagnostic clinic for handicapped children in the development of the concepts presented in this paper: Ruth Baumgartner and Eleanor Jantz, clinical psychologists; Barbara MacDonald, medical social worker; John Carter, speech pathologist; and Bertram Thorne, audiologist.

When you study the intricate process of human reproduction which can fail at so many points, you no longer wonder at the cases of infertility but wonder instead that any baby is ever born!

Alan F. Guttmacher, M.D., and Joan Gould in "Why Can't You Have a Baby?" *Public Affairs Pamphlets, 1961.*

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[1] Bond, E. D.; Smith, L. H.: Post-encephalitic behavior disorders: a 10-year review of the Franklin School. *American Journal of Psychiatry,* 92: 17, 1935.

[2] Blau, A.: Mental changes following head trauma in children. *Archives of Neurology and Psychiatry,* 35: 723, 1936.

[3] Pasamanick, B.: The epidemiology of behavior disorders of childhood. *Research Publications of the Association for Research in Nervous and Mental Disorders, Proceedings,* 34: 397, 1954

[4] Kahn, E.; Cohen, L. H.: Organic drivenness: a brain stem syndrome and experience. *New England Journal of Medicine,* 210: 748, 1934.

[5] Strauss, A. A.; Werner, H.: Disorders of conceptual thinking in the brain-injured child. *Journal of Nervous and Mental Disease,* 96: 153, 1942.

[6] Strauss, A. A.; Lehtinen, E. L.: Psychopathology and education of the brain-injured child. Grune & Stratton, New York, 1950.

[7] Lewis, R. S.: Strauss, A. A.; Lehtinen, E. L.: The other child. 2d edition. Grune & Stratton, New York, 1960.

[8] Bradley, C.: Characteristics and management of children with behavior disorders associated with organic brain damage. *Pediatric Clinics of North America,* 4: 1,049, 1957.

[9] Eisenberg, L.: Psychiatric implications of brain damage in children. *Psychiatric Quarterly,* 31: 72, 1957.

[10] Laufer, M. N.; Denhoff, E.; Solomons, G.: The hyperkinetic impulse disorder in children's behavior problems. *Psychosomatic Medicine,* 19: 38, 1957.

[11] Rogers, M. E.; Lillienfeld, A. M.; Pasamanick, B.: Prenatal and paranatal factors in the development of childhood behavior disorders. *Acta Psychiatrica et Neurologica Scandinavica Supplementum,* 102: 1, 1955.

[12] Knobloch, H.; Pasamanick, B.: Syndrome of minimal cerebral damage in infancy. *Journal of the American Medical Association,* 170: 1,384, 1959.

[13] Bender, L.: The psychological problems of children with organic brain disorders. *American Journal of Orthopsychiatry,* 19: 404, 1949.

[14] Luria, A. R.: An objective approach to the study of the abnormal child. *American Journal of Orthopsychiatry,* 31: 1, 1961.

[15] Cohn, R.: Delayed acquisition of reading and writing abilities in children. *Archives of Neurology,* 4: 153, 1961.

[16] Bender, L.: Psychopathology of children with organic brain disorders. Charles C Thomas, Springfield, Ill., 1956.

[17] Ingram, T. T. S.: Specific developmental disorders of speech in childhood. *Brain: A Journal of Neurology* (London), 82: 450, 1959.

[18] Nykelbust, H. R.; Boshes, B.: Psychoneurological learning disorders in children. *Archives of Pediatrics,* 77: 245, 1960.

[19] Wood, N.: Language disorders in children. *Monographs of the Society for Research in Child Development,* 25: 15, 1960.

[20] Hallgren, B.: Specific dyslexia: a clinical and genetic study. *Acta Psychiatrica et Neurologica Supplementum,* 65, 1950.

[21] Ingram, T. T.: Pediatric aspects of specific developmental dysphasia, dyslexia, and dysgraphia. *Cerebral Palsy Bulletin,* 2: 248, 1960.

[22] Orton, S. T.: Specific reading disability—Strephosymbolia. *Journal of the American Medical Association,* 90: 1,095, 1928.

[23] Hanvik, L. J.; Nelson, S. E.; Hanson, H. B.; Anderson, A. S.; Dressler, W. H.; Zarling, V. R.: Diagnosis of cerebral dysfunction in childhood. *American Journal of Diseases of Children,* 101: 364, 1961.

[24] Tannhauser, H. T.: Educational management of children with communication disorders. *Proceedings of Maryland Child Growth and Development Institute,* June 1959. (Available through the Maryland State Department of Health.)

[25] Taterka, J. H.; Katz J.: Study of correlations between electroencephalographic and psychological patterns in emotionally disturbed children. *Psychosomatic Medicine,* 17: 63, 1955.

[26] Poser, C. M.; Ziegler, D. K.: Clinical significance of 14 and 6 per second positive spike complexes. *Neurology,* 8: 903, 1958.

[27] Rabinovitch, R. D.; Drew, A. L.; DeJong, R. N.; Ingram, W.; Withey, L.: A research approach to reading retardation. *Research Publications of the Association for Research in Nervous and Mental Disorders, Proceedings,* 34: 363, 1954.

[28] Kennard, M. A.; Rabinovitch, R. D.; Wexler, D.: The abnormal electroencephalogram as related to reading disability in children with disorders of behavior. *Canadian Medical Association Journal,* 67: 330, 1952.

TWO STUDIES OF UNMARRIED MOTHERS IN NEW YORK CITY

HANNAH M. ADAMS
Research Analyst, Division of Research, Children's Bureau

KNOWLEDGE OF NEEDS of unmarried mothers and their use of a large urban community's health and social services has been augmented by two recent studies in New York City, one a joint project of the local health and welfare departments,[1] and the other undertaken by the Community Council of Greater New York under the sponsorship of the New York State Department of Social Welfare,[2] with the use of Federal child welfare services funds. Both studies grew out of concern over the increasing number and rate of illegitimate births in the city, the high perinatal mortality rate among children born out of wedlock, and the apparent fact that many unmarried expectant mothers do not make use of, or delay using, facilities which the community provides for medical care, casework counseling, shelter care, or other social services.

At the present time about 13,000 children are born out of wedlock yearly in New York—8 percent of all live births. Similarly, in Chicago 9 percent and in Philadelphia 8 percent of all live births are out of wedlock.[3] An estimated 200,000 babies are born out of wedlock throughout the United States each year, about 5 percent of all live births.[4]

The report by New York City's health and welfare departments is a statistical analysis of all birth certificates in the city and matched infant death certificates for the years 1955–59, with special attention to births out of wedlock, together with compilation of facts on illegitimate children in the welfare department's caseload. The Community Council study, on the other hand, is based on interviews with 520 unmarried mothers in hospitals following confinement to learn what services they had sought during pregnancy and their reasons for not seeking services sooner or at all. A review of the two studies underlines the fact that, essential as comprehensive analyses of statistical records are, they need to be supplemented by more intensive examination of individual cases if underlying problems are to be uncovered.

Both studies showed that a large proportion of unmarried mothers received inadequate prenatal medical care. About half of them did not obtain care during the first 6 months of pregnancy, including 15–17 percent who had had no care up to confinement except perhaps a single visit to a doctor or clinic to confirm pregnancy. The contrast with the extent of prenatal care among married mothers in the city was marked. In addition, the Community Council study found an even greater proportion of unmarried mothers who had had no contact with a social agency during pregnancy—29 percent—than had received no medical care. Moreover, nearly one-half had been in touch only with the welfare department's bureau of public assistance, which in many cases was meeting financial need unconnected with the pregnancy.

Who They Were

In 1959 one-third of all births in New York City were to nonwhite or Puerto Rican mothers. In the Community Council study, 62 percent of the mothers interviewed were Negro and 19 percent Puerto Rican, an approximation of the racial and ethnic proportions of all births out of wedlock in the city in 1959. Although most of the Negro and Puerto Rican mothers had lived in New York as long as 3 years, more than half of the Negroes had spent their childhood in the South and almost all the Puerto Ricans had passed their childhood years in Puerto Rico. Thus many of the unmarried mothers had been brought up in a rural environment where the legalizing of family relationships is not always regarded as so important as in an urban society, and where the people are not used to having a network of health and social services available.

The authors of these two studies have analyzed all their data by ethnic group without regard to socioeconomic status, which might be a more appropriate basis for classification. While statistics on occupations [5] give some justification for making an assumption of economic status on the basis of ethnicity, in a study involving interviews with unmarried mothers, some direct measure of the socioeconomic status of each mother is important. A determination of the occupation of the unmarried mother's father or mother might have been made to supplement the information on her own occupation, since so many in the group did not work outside the home or were too young to have had much work experience.

Both studies are, of course, limited to identified out-of-wedlock births, and it may well be that unmarried mothers of higher economic or social status are more successful than others in concealing the fact that they are not married. In the 5-year period studied by the health department, 95 percent of all identified out-of-wedlock births occurred in municipal hospitals or on the wards of voluntary hospitals, and less than 5 percent were to private patients in voluntary or proprietary hospitals. A further possible source of bias besides lack of identification of illegitimate birth status was introduced in the council study, as its authors note, by exclusion of proprietary hospitals. However, the possible overweighting of available information on unmarried mothers with women of lower economic class is not important in planning community services.

Prenatal Care

The council study's interviews furnished a wealth of detail about how the unmarried mothers went about obtaining medical care. About the same number went first to a clinic as went first to a private physician, but most of them finally had clinic care before their babies were born.

About 21 percent of the unmarried mothers interviewed began regular prenatal care in the first 3 months of pregnancy, 32 percent started regular care in the second trimester, another 9 percent began care in the first or second trimester but did not continue it regularly, 21 percent first obtained care in the seventh or eighth month, and 17 percent obtained no prenatal medical care though half of these were seen once by a doctor.

The small group of unmarried mothers under 17 years of age (8 percent of the sample), delayed care more than the others, but only a small proportion of them—9 percent—received no prenatal care whatever.

The difference between unmarried and married mothers in amount of prenatal care was striking. Community Council investigators estimated from official figures that nearly one-half of all married mothers in New York City in 1959 started care in the first trimester of pregnancy, compared with but one-fourth of the unmarried mothers studied. Only about 3 percent of married mothers obtained no prenatal care, compared with 17 percent of the unmarried mothers. The health department's analysis of data on prenatal care reported on birth certificates for the 5 years, 1955–59, showed that nonwhite and Puerto Rican married mothers, though tending to begin prenatal care later than white married women, had a better record than unmarried mothers of any of the three groups.

Some Hazards

Some of the hazards of unwed motherhood documented in the health department's study were:

1. A higher proportion of out-of-wedlock than in-wedlock births were premature. This held true for all groups, although nonwhite and Puerto Rican married women had a higher rate of prematurity than white unmarried women.

2. The death rate was high for infants born out of wedlock—48.2 per 1,000 live births, during the 5 years studied. For all infants born in wedlock it was 23.9 and for nonwhite infants born in wedlock, 38.3.

3. Both prematurity and infant mortality were associated with lack of prenatal care. In 1958 more than one-fourth of the unmarried mothers who had no prenatal care had premature babies, compared with one-eighth of those who had some prenatal care. Over the 5-year period studied, 116 babies died out of every 1,000 born to unmarried mothers who had not had prenatal care. Only 32 babies died per 1,000 live births among unmarried mothers who

had had prenatal care—a more favorable rate than among the babies of married mothers who lacked prenatal care.

Social Services Received

The finding that fewer of the interviewed unmarried mothers used the community social services than used medical care facilities available to them poses questions regarding both their needs, or recognized needs, for service and the nature of the programs now provided. About 29 percent were known to no social agency during pregnancy. The study, of course, had no information on how many may have turned to social agencies following the birth of the baby.

Less than a fifth of all the interviewed mothers had been served during pregnancy by agencies with specialized shelter, adoption, or counseling programs for unmarried mothers; a third had been served by other agencies offering casework treatment (such as hospital social service departments, the welfare department's bureau of child welfare, or family service or foster care agencies), but not by the specialized agencies; 2 percent were known only to school or court counseling services (or to these services plus the welfare department's bureau of public assistance); 16 percent were known only to the bureau of public assistance.

A good many unmarried mothers received service from more than one type of agency. In all, 40 percent were in contact with hospital social service departments, although 88 percent had been served by hospital clinics. One-third of the total received financial assistance through the city's bureau of public assistance. Twelve percent were known to the city bureau of child welfare, which sometimes pays for care in a maternity shelter.

Variations were great. Of the girls under 17, 90 percent received some type of social agency service and 50 percent received services from agencies offering shelter care, adoption service, or specialized counseling for unmarried mothers. Ninety percent of the white unmarried mothers (not including Puerto Ricans) of all ages were also known to social agencies, the great majority to specialized agencies. In contrast, only 5 percent of the Negro and 10 percent of the Puerto Rican mothers were served by specialized agencies. While 40 and 30 percent, respectively, of these two groups were known to social services in the clinics, a third were not known to any social agency.

Ten percent of the interviewed mothers had come to New York after they became pregnant. A slightly greater proportion of them received agency service than of those who lived in New York before pregnancy. Three-quarters of these newcomers reached social agencies, and half reached specialized agencies before confinement. Social service was also sought more often by the more educated unmarried mothers than by the less educated.

The great majority of the interviewed mothers—77 percent—told the interviewer that they planned to keep their babies with them. Only 18 percent were working with a social agency on plans for adoption, while a few others planned to place the child with relatives or in a foster home, or had reached no decision.

Among Negro unmarried mothers, 87 percent intended to keep the baby and but 8 percent to give it up for adoption. An even higher proportion of Puerto Rican mothers, 95 percent, planned to keep their children, and most of them had not discussed their plans for their child with anyone—not even a friend—before the council's study interview. On the other hand, two-thirds of the white mothers were already planning through an agency to give their babies up for adoption, while only a little over one-fourth expected to keep their babies.

It cannot be concluded, of course, that all the children whose mothers intended, at the time they were born, to keep them will actually remain with their mothers. Some will presumably be placed for adoption or in foster care independently by their mothers. Others will turn up later in agencies and may, because of the shortage of adoption homes, remain in foster care.

Deterrents to Services

Why did so many of the unmarried mothers in the Community Council study fail to seek, or put off seeking until so late, the prenatal care so important to the welfare of mother and child? And why did even more of them fail to use the services of a social agency, which might have guided them to medical care facilities or needed financial assistance, or might have discussed with them plans for themselves and their children?

Each mother interviewed was asked these questions along with others designed to bring out how much she knew about community facilities and the kinds of services which they provide, and her attitude toward them.

The mothers' reasons for not using prenatal medical care facilities and for not using social services were somewhat similar, except for the fact that many of them had no acquaintance with the kinds of services social agencies offer to unmarried mothers, while practically all knew of places to obtain medical care.

In the case of prenatal medical care, several reasons often combined to deter prompt and regular use of facilities, with no one reason outstanding. The reason most often given by the unmarried mothers was that they saw no need to begin care until late in pregnancy. The inconvenience of attending clinic (often complicated by their responsibilities to other children), interference with a job, a desire to conceal pregnancy as long as possible, and not knowing that the pregnancy existed were other reasons given. In the judgment of the interviewers, concealment of pregnancy delayed care for about three-fourths of the school-age girls, though only for 18 percent of the entire group.

Certain other deterrents were related to specific situations or agency practices. For example, the unmarried mothers tended to be easily discouraged in their efforts to obtain medical care by any refusal of service—whether this was because they went to a facility in the wrong district, or, as sometimes happened, were told to get their parents' consent to attend the clinic. Often agencies failed to follow through on referrals. School personnel and public assistance visitors too often could not make referrals because they did not know about the pregnancy. Some of the young women had not even told their own mothers until late in the pregnancy. Many mothers who were told delayed seeking prenatal care for their daughters and helped to keep the school from learning of the pregnancy.

As for social services, a good deal of ignorance and understanding of social agency programs was revealed in the interviews. A majority of those mothers who had had no contact with any social agency did not know about any agency. Many others knew only about the bureau of public assistance or the hospital social service departments. Unmarried mothers who did get to casework agencies usually did not go directly on their own initiative, but were referred by other agencies or clinics, or sometimes by relatives, clergymen, or private doctors. When asked if they would refer a pregnant friend to a place to talk over her problems and get advice and help, about half of all those interviewed replied that they did not know of any such place.

Yet the extent that lack of information deterred unmarried mothers from obtaining services they desired for themselves or their babies is open to question. The interviewers judged that the major deterrent to using social services was that the expectant mothers saw no need for such services; that this was behind about half the delays or failures to seek social services. For only about 1 out of 10 was lack of knowledge of agencies considered the real deterrent. Another 15 percent, including two-thirds of the young teenagers, were judged to be deterred in seeking social service by a wish to conceal pregnancy.

Failure to See Need

The failure to recognize the need for service also shows up in some of the detail given in the council report regarding use of specific types of service. For example, a majority of the unmarried mothers known to clinics were not known to the clinic's social service department, although social services are available in the prenatal clinics of all the hospitals in the study to all unmarried mothers who seek them. The reason most commonly given by the mothers for not seeing the clinic's social worker was that they did not see any need to do so, at least until they needed some concrete assistance.

Some of the large number of mothers who did not use shelter or adoption agencies showed by their comments that they tended to regard such agencies as for unmarried mothers who had decided to give up their children. But most of the mothers who planned to keep their babies or had not reached a decision did not know of agencies that could help them.

To sum up, the chief reason why the unmarried mothers who were interviewed did not seek social services was that they did not see themselves as needing the things which they thought social agencies were chiefly concerned with providing. In fact, they tended to look on social agencies as providers of tangible things rather than as places to talk over plans and obtain help in making decisions.

However, there were some mothers who wanted but did not obtain specific services which they either did not know where to find or for which they were unwilling to pay the price they expected would be asked them. For instance, 10 percent of those interviewed were in serious financial need but did not apply for public assistance. Among their reasons for not applying were fears that support would be sought from the putative father, that relatives would learn of the pregnancy, or that their children would be taken away from them.

The concern over increasing births out of wedlock and the high death rate among babies so born which prompted both studies demanded not only presentation of facts relating to these problems but also some attention to ways of coping with them. Since further increase in the volume, and possibly in the rate, of out-of-wedlock births in New York City can be anticipated, in view of changes in age and socioeconomic characteristics of the population, programs are needed to help remove deterrents to the use of health and social services by unmarried girls and women who become pregnant. In their interpretation of their statistics, the city departments of health and welfare stress the importance of broad community measures to raise the standard of living of *all* underprivileged families—measures relating to employment opportunities, wages, housing, education, medical care, recreation. Yet both studies also show that unmarried mothers and their children are especially disadvantaged, and thus require special efforts on the part of the community to see that they get the services they need.

Suggestions for Action

The council's study of deterrents to good care in 520 cases includes some specific suggestions for the strategy of such a program.

To reach teenage pregnant girls:

- The broadening of family life education courses in junior and senior high schools and the provision of neighborhood parent education courses as possible channels for impressing on young girls and their parents the importance of seeking early medical care during pregnancy.
- Assumption by school personnel of more responsibility for counseling pregnant girls and referring them to appropriate services, and the modification of school policies in regard to expulsion in order to break down the girl's fear of telling the school counselor about her pregnancy.

To reach older unmarried mothers who do not appreciate their need for medical and social services:

- Providing instruction regarding the importance of such services, in strategic places such as maternity hospitals or general medical clinics, or child health stations.
- Equipping the city's public assistance workers for taking a more active part in dealing with other than financial needs of the unmarried mothers in their caseloads, and for making and following up referrals of these women to appropriate services.
- The assumption of more responsibility on the part of doctors and clinics for referring unmarried mothers to appropriate facilities for medical care and social services, and for making sure that care is received.
- Reaching out by caseworkers of clinic social service departments to extend counseling to all unmarried mothers attending clinics whether or not they ask for it.

At present a girl may go to see a hospital social worker because she is required by clinic policy to do so, but if she says she is going to keep her baby may be offered no further counseling. The council's report recognizes that extension of counseling to every unwed mother would not be possible without the enlargement of present social service staffs.

Both these reports point out that success of plans to remove deterrents to early prenatal care and social services for women and girls pregnant out of wedlock would create a greatly increased demand for all kinds of services for both mothers and babies, possibly far beyond the present capacity of the community's facilities to supply. Part of this new demand could require expansion of shelters and adoption agencies because more unmarried mothers might wish these services as they learned about them. Part of it might require specially developed programs of supportive services for unmarried mothers who keep their children.

In either case, a community which decides to encourage a demand for services must be ready to meet that demand.

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[1] Pakter, J.; Jacobziner, H.; Rosner, H. J.; Greenstein, F.: A study of out-of-wedlock births in New York City. Paper presented at 88th annual meeting of the American Public Health Association, San Francisco, November 1960.

[2] Bernstein, B.; Sauber, M.: Deterrents to early prenatal care and social services among women pregnant out-of-wedlock. New York State Department of Social Welfare, Albany, 1960.

[3] U.S. Department of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics: Illegitimate births; United States, 1938–57. Vital Statistics Special Reports, vol. 47, No. 8, Sept. 30, 1960.

[4] ———: Illegitimate births; fact sheet. Apr. 15, 1960.

[5] U.S. Department of Labor, Bureau of Labor Statistics: Special labor force reports, No. 4. 1960.

A SOCIAL PERSPECTIVE FOR BEHAVIOR

MARSTON M. McCLUGGAGE

Professor of Sociology, University of Kansas

THE SOCIETAL and cultural factors affecting behavior have long received recognition by persons working with children. However, this awareness has often been diffuse, unsystematic in its application, and sometimes even overlooked or ignored in practice. Often the social factors have been recognized, but not systematically analyzed. In a recent publication, "Social Systems, Essays on Their Persistence and Change," Charles P. Loomis has presented a conceptual framework for the analysis of social systems[1] and applied it in the examination of a number of specific systems. These include communities undergoing industrial development; communities under the stress of disaster; religious systems in a transitional stage; the educational systems of the United States, the Soviet Union, and Mexico; and health systems such as the hospital and the doctor-patient relationship.

Persons working with children in an organizational context, be it hospital, school, clinic, or institution, may find that an awareness of this theory sensitizes them to significant factors in their own environment. It may help them guard against explaining behavior exclusively in terms of psychological factors. It may serve as a guide to the diagnosis of social and cultural factors operating in whatever is under examination, whether it is a community or a parent-child relationship.

Social systems, according to the author, consist of the patterned interaction of the members who make up the system. This interaction he sees as the product of shared symbols and expectations involving reciprocal rights and obligations among the members. The elements that make up the system and the processes by which these become dynamic are presented as integrated phenomena. Among the processes discussed with the related element (in parentheses) are knowing (knowledge or belief), feeling (sentiment), achieving (goal), evaluating (norm), distributing the functions of the system (status-role), ranking (rank), decisionmaking and controlling (power), application of sanctions (sanction), utilization of the facilities of the system (facility). Each of these processes and elements is activated by comprehensive social processes such as communication, the maintenance of the social system's boundaries, the linkage with other social systems, socialization, social control, and institutionalization.

Somewhat in the manner of Homans,[2] the author analyzes the adaptation of the social system to the demands of the external environment and the adjustments made for the internal satisfactions of the members. These he sees as related to each other in a process which tends to achieve an equilibrium between the external demands and internal factors.

In a system in equilibrium, any of the elements or processes may be crucial. Those of special significance to persons working with children are sentiments, tension management, norms and the evaluative process, role performance, and ranking. Sentiment is the chief factor in the internal system, and awareness of the way it may upset the most rational of formal structures is of crucial importance. Norms are the value-laden "rules of the game." Status or rank in the social system and role performance are of fundamental utility for the analyst of behavior.

Roles are the media through which a society distributes its different social functions and meets its needs. Role theory serves to explain how a society distributes its different social functions, how one person with multiple roles may have a variety of responses, and how society directs persons of diverse psychological trends into standardized patterns of behavior. It enables us to explain why people with obviously different personalities may be engaged in similar activities, and why many persons with similar psychological characteristics may be found involved in different activities. It may also serve to explain why many persons exposed to bad social conditions, such as social inequality, social conflict, and economic deprivation, do not engage in antisocial behavior.

Rank as an aspect of social systems currently finds much emphasis in the analysis of delinquency, particularly among sociologists who, like Merton,[3] have pointed to the gap between the culturally induced goals and the socially approved means to achieve them.

The essay in which Loomis applies his conceptual scheme to the analysis of communities and societies undergoing change from a communal (Gemeinschaft) to an associational (Gesellschaft) basis is particularly relevant for persons who are working in an environment undergoing similar change. In the Gemeinschaft-like groups, human relations are ends in themselves, intimacy and sentiment are prevalent in the members, norms are traditional, obligations are unlimited, and both moral and ethical in character. There is a spontaneous bond or feeling of belonging. In Gesellschaft systems, relations with others tend to be based on reason, not feeling; obligations are limited and specific; there is much concern with self-interest; norms tend to be rational; interaction is impersonal and affectively neutral. There is a tendency to treat people as means to serve our own immediate ends.

Not only is this shift from Gemeinschaft to Gesellschaft apparent in underdeveloped countries but also within American society where migrants from rural areas to the cities or from one industrial area to another experience aspects of this change. Many personal and social problems in American society are closely related to conditions of isolation, loneliness, and anomie associated with this trend in social organization.

Loomis' study emphasizes social structure as the source of a great part of our social problems. It suggests the usefulness of viewing delinquent behavior as the product of stresses in the culture or of looking for the roots of personality disorder in the area of role taking. For example, there may be implications for mental health in the lack of integration in the various roles a person plays; in the discontinuity of roles between childhood, adolescence, and adulthood; or in the failure of role behavior to bring expected results.

Undoubtedly, the values and norms of the social system play their part in creating stress. For example, the emphasis on competitiveness, aggressiveness, a high order of achievement, material well-being, and conformity, along with an exhortation urging cooperation, love, and humility takes its toll in tension and internal conflict.

Thus each of the elements and processes in the social system might be examined for their contributions to the functioning or malfunctioning of our society.

The strategy suggested by this approach for the improvement of mental health and the more effective development of personalities is to search for institutional changes and seek alterations in the situations that produce disorder. There is no possibility in the near future of training enough clinicians to treat problems of maladjustment and disorder on an individual basis, even if this were an adequate approach. Therefore it is essential that we use our trained personnel more effectively in preventive work. This points toward the necessity of understanding social systems and the way their malfunctioning or inadequate adaptions to change bring about social problems.

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[1] Loomis, Charles P.: Social systems; essays on their persistence and change. D. Van Nostrand, Princeton, N.J., 1960. 349 pp.

[2] Homans, George C.: The human group. Harcourt Brace, New York, 1950.

[3] Merton, Robert: Social structure and anomie and continuities in the theory of social structure and anomie. *In* Social theory and social structure, Free Press, Glencoe, Ill., 1957.

Future Directions of UNICEF

MAURICE PATE

Executive Director, UNICEF

AS A RESULT of decisions reached by its Executive Board at its annual meeting in New York, June 8–19, 1961, the United Nations Children's Fund (UNICEF) is now prepared to offer a wider variety of aid to governments ready and willing to undertake broad programs to meet the needs of children in the developing countries.

Since well-conceived programs to meet such needs require expert planning based on a careful appraisal of local conditions and resources, UNICEF, working in close cooperation with the specialized agencies associated with the United Nations, is also ready to assist governments in analyzing the priority needs of their children and drawing up practical action programs to deal with these needs.

Major Needs

Until a little over a year ago (see CHILDREN, May–June 1960, p. 118), UNICEF concentrated its assistance on the fields of health and nutrition. A preliminary survey of the needs of the world's children, carried out at the behest of the 1960 session of the Executive Board has indicated that, in many underdeveloped countries, little permanent progress in child health and nutrition can be achieved without related progress in education and social welfare. It has also revealed a wide variation in the order of priority different governments assign to the needs of their children. For example, most of the Asian countries assign highest priority to health and nutrition. In Africa, education is frequently regarded as the most urgent problem. In parts of Latin America, it is the plight of abandoned children.

Twenty-four beneficiary governments participated in the survey. They all recognized the importance to them of UNICEF aid in the eradication of mass diseases such as malaria, the establishment of permanent mother and child health services, and the attack on hunger and malnutrition. A number of them, however, requested UNICEF to broaden the scope of its aid to include other high-priority programs—in particular, programs involving broad social services, general education, and preparation of the child for adulthood.

Adapting to Change

As a number of delegates pointed out, the rate of social and economic change in the developing countries is accelerating, and the flow of multilateral and bilateral aid, already in excess of $4 billion a year, is also steadily increasing. UNICEF's share in this is a small one, about $25 million a year; and although its resources have been growing at the rate of about $2 million a year and in all probability will continue to grow, it is coming to represent a smaller proportion of the field.

In the coming decade, the Board decided, what UNICEF does to influence others may be more important than the direct results of its own work. It therefore concluded that the agency's principal mission from now on should be to demonstrate how child welfare programs can be more closely tied to the general development plans of governments—particularly those undergoing rapid economic transformation. To carry out this mission, the delegates agreed, UNICEF must continue to work in close collaboration with the U.N. specialized agencies and the U.N. Bureau of Social Affairs.

Since the Bureau of Social Affairs will be called on by UNICEF for an increasing amount of technical advice and support, in its formal report to the Economic and Social Council, the Board stressed the urgency of augmenting the Bureau's staff to assist governments in drawing up plans to meet the social welfare needs of children.

The Board also emphasized the fact that UNICEF must continue to cooperate at all levels, from the planning of projects to their final execution, with the various bilateral and multilateral assistance programs that are being extended to the underdeveloped world.

As industrialization proceeds in the developing countries, a number of delegates emphasized, broad social services for the protection of children in the fast-growing urban centers must be planned and established as rapidly as possible. Therefore, the Board decided to offer UNICEF assistance to governments of developing countries in surveying the needs of their children and in planning programs to meet these needs as an integral part of their larger economic and social development plans. An initial sum of $100,000 was allocated for this new program. None of the delegates expressed opposition to the urgency or the desirability of this form of assistance, but a number of them questioned whether $100,000 would be enough, even as a preliminary allocation.

Training Emphasized

For some time, it has been evident that supplies, transportation, and foreign exchange are not the only bottlenecks that underdeveloped countries have to worry about in carrying out programs to meet the needs of their children. The most intractable obstacle is often the "personnel bottleneck"—the lack of trained teachers, health workers, social service workers, agricultural extension consultants, and food technicians.

In recent years UNICEF has been steadily increasing its aid for training. Training allocations jumped from $1,200,000 in 1959 to $2,400,000 in 1960. Even more emphasis on training can now be anticipated.

The Board specifically recommended that "training assistance should be available for all categories of personnel who furnish services concerning children and mothers." Local conditions and needs as determined by the governments of the countries concerned will be the ruling consideration.

It now appears that UNICEF assistance in the fields of general education and broader social services will first materialize as aid to the training of teachers and social workers in underdeveloped countries.

Antimalaria Drive

In 1955 UNICEF joined the World Health Organization and various bilateral aid programs in a drive to stamp out malaria in Asia, Latin America, and the Eastern Mediterranean. For several years, aid to malaria eradication has been the largest single item in UNICEF's budget. In some countries—Mexico, for example—eradication is now entering its final stage of "consolidation," and the benefits, not only in terms of child health but also in general economic and social progress, have been tremendous. In a few countries, however, eradication programs have run into serious obstacles.

Last year the Board decided that an appraisal of continued large-scale UNICEF assistance in the antimalaria drive was in order. At the Board's request, WHO drew up a detailed review of the program as carried out in various parts of the world. The Board has now decided to continue UNICEF's aid to malaria eradication and control in countries where the chances of success seem good and where governments are willing and able to provide the necessary support. This includes the great majority of countries where eradication programs are already underway. Furthermore, UNICEF will support promising new eradication programs. It has already agreed to aid the United Arab Republic in such a drive in Egypt.

The Board decided, however, that it would be pointless to maintain costly antimalaria operations in countries "whose governments are unwilling or unable to make the necessary effort to eradicate malaria" or in countries where for other reasons malaria eradication does not yet seem to be feasible.

An important point brought out in the debate was that there is no known method of permanently eradicating malaria in a country lacking a fairly adequate network of local health and sanitation centers. In many regions, therefore, notably tropical Africa, malaria eradication can only be carried out as part of a larger program to strengthen basic public health services. The joint goal of UNICEF and WHO in tropical Africa will be precisely this strengthening of basic health services.

Other Programs

Because of the somewhat conservative financial practices followed by UNICEF in the past, actual expenditures have lagged behind income, and the unspent portions of its allocations have been accumulating. The Board accordingly approved proposals for disbursing UNICEF's resources at a faster rate over the next 5 years. Consequently, UNICEF will be able to allocate more than $30 million this year and, if contributions continue to rise at the present rate, almost $33 million in 1962 and $35 million in 1963.

Despite the wider range of assistance to be offered the governments of underdeveloped countries, no radical shift in the content of UNICEF aid is anticipated in the near future. Allocations for the antimalaria campaign, which will come to about $9,400,000 this year, will continue to be the largest single item in UNICEF's budget, but will still be within the $10-million-a-year limit that UNICEF has imposed for this program.

Campaigns against tuberculosis, leprosy, yaws, trachoma, and other mass diseases will be allocated about $2,100,000 this year; their share is expected to rise to $2,500,000 in 1963. Annual allocations for health services and family and child welfare are expected to rise from $6 million in 1961 to $7,400,000 in 1963. Allocations for nutrition—a category that covers dairy projects, the development of new protein-rich foods, nutrition education and related activities, and powdered milk distribution—are expected to rise from $7,600,000 to $9,700,000 in the period.

Annual allocations for the new types of programs envisaged by the Board, including aid to general education, broad social services, assistance to national surveys of the needs of children and planning programs to meet the needs, will, it is anticipated, have risen to no more than $4 million by the end of 1963.

New Projects

Among the specific new projects approved was a social service program for the Republic of the Congo to initiate training for unemployed youth and to stimulate village self-help. The Congo also received a $177,000 emergency allocation to prevent famine and $205,000 to transport health personnel.

Another new project for the African region involves the training of national staff for teaching, directing, and supervising posts in nutrition departments, and for agricultural and home economics extension. The shortage of trained national personnel has been one of the main reasons why UNICEF has been able, so far, to give little help for the improvement of child nutrition in Africa south of the Sahara.

In Costa Rica, UNICEF will be assisting a broad national program of social services for children by providing stipends, scholarships, and teaching equipment for the training of social service staff, and by equipping community centers and residential institutions for children.

Significant Precedent

UNICEF, as one of the delegates remarked, must move into the future not only with audacity but with prudence. But while UNICEF cannot spend a great deal of money on new types of programs in the immediate future, an important precedent, the members of the Board agreed, has now been established: that UNICEF cannot afford to turn its back on a request for assistance in any field relating to the needs of children.

Educators have a challenge in this decade, but it is not only to teach science. It is to teach humanity: for without that, science already has answers we dare not hear.

Francine Richard, Editor, Illinois Education, *in* Edpress Newsletter, *February 13, 1960.*

HERE AND THERE

Conference on School-Age Children

A 2-day conference on the growth and development of the "middle-aged child"—the child from 6 to 12—was held in Morgantown, W. Va., at the University of West Virginia Medical School on June 21–22, 1961. The conference was sponsored jointly by the division of maternal and child health of the West Virginia State Department of Health and the division of crippled children's services of the West Virginia State Department of Public Assistance. The participants included physicians, nurses, nutritionists, social workers, educators, and other professional groups working with children.

Dr. N. H. Dyer, director of the State health department, summarized the conference held under the same auspices a year ago on the preschool child, thus bringing into focus the importance of continuity in considering the needs of children.

In the keynote address presenting past accomplishments and future needs in regard to health services for children, Dr. Arthur J. Lesser of the Children's Bureau pointed out that further progress would require existing health services to cope with problems of: increasing child population; social changes; increasing cost of medical care; changing practices in medicine and public health resulting from research; professional manpower; the provision of sufficient prenatal care for all expectant mothers; hospitalization for complications of pregnancy and for infants in need of special care; and expansion of services for mentally retarded children. He also outlined major problems in providing care for handicapped children, and anticipated a closer coordination and an extension of established services for children with various types of handicaps.

Discussants stressed the close association between the physical, personality, and cultural growth and development of the child from 6 to 12, and emphasized the importance of knowing what each child was like.

A report on recent research in the development of skills in children emphasized the importance of providing the child with adequate stimulation and the proper environment for development.

Other points brought out in the conference were:

- Professional persons must understand attitudes of society and parents toward the physically handicapped child before they can expect facilities to be fully used.
- The age factor and the period in life in which a handicap is experienced influences the opportunities of children for care.
- Parent counseling for children between 6 and 12 could be more effective if professional workers would appreciate the intuitive wisdom, the creativeness, and the responsiveness of children of this age.
- Accident prevention is a basic part of how people live—not a task to be added to other activities.
- A thorough knowledge of growth and development principles and problems, coupled with basic facts concerning accidents and injuries, is essential to effectiveness in programs for this age group.

The participants agreed that another conference should be held next year with focus on the adolescent child.

—Madeleine E. Morcy, M.D.

Physical Fitness

The President's Council on Youth Fitness has issued a document providing a framework for a school-centered program to build physical fitness among the Nation's young people. The document was distributed in July to school boards, school administrators, and others throughout the Nation along with a message from President Kennedy calling the Nation's schools and colleges the "decisive force in a renewed national effort to strengthen the physical fitness of youth." It recommends that as a minimum program the schools adopt a plan including three steps:

- Health appraisals for all school children, including tests using techniques of measuring flexibility, agility, and strength to identify those who are underdeveloped physically; to provide developmental activities for the underdeveloped pupils to help them reach adequate levels of performance; and to retest every 6 months those children found to be under par.
- At least 15 minutes of vigorous exercises and developmental activities within the school's daily period of physical education.
- Periodic tests of "physical achievement" for all pupils to measure their progress and to motivate them toward higher levels of fitness.

The document was prepared after consultation with representatives of State school officers and school superintendents, parochial and private schools, the U.S. Department of Health, Education, and Welfare, the American Medical Association, and the American Academy of Pediatrics.

Specific suggestions on tests and activities that could be included in such a program have been added to the document in a publication now available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C. ("Youth Physical Fitness: Suggested Elements of a School-Centered Program, Parts 1 and 2." Price, 40 cents.)

Social Research

About three-fourths of the independent adoptions studied in Florida have been rated good to fair in outcome, in the large-scale followup study initiated in that State 5 years ago. (See CHILDREN, May-June 1956, p. 115.) The study, covering 484 such adoptions completed in the State during 1944–47, was undertaken by the Children's Bureau and the Florida State Department of Public Welfare, and financed by the Russell Sage Foundation.

The goals were chiefly to determine (1) how the independent adoptions made under the Florida system seemed to be working out; (2) what factors, if any, in parents, children, homes, and histories distinguish placements that work out well from those that do not: and (3) which of these, if any, can be determined at the time of placement.

Adoption outcomes were judged on the basis of (1) home ratings made by experienced caseworkers, after extended interviews with adoptive parents (usually the mother); (2) independent measures of the child's adjustment, including teacher and peer ratings and self-ratings; and (3) information from school records.

Among other findings were the following:

- From one-fourth to one-third of the children were living in homes categorized by the investigators as "poor."
- Children in "poor" homes were far more likely to be judged poorly adjusted than children in homes rated "good" or "excellent."
- A low proportion of the children in the study had health handicaps, and these were, for the most part, types of handicaps not discernible before adoption.
- An adverse preplacement history did not in itself necessarily appear to interfere with a child's later adjustment.

According to the investigators, most objective criteria, such as age of adoptive parents, showed little relation to the way the placement worked out. Criteria of importance were found to be rather in the social-psychological sphere, such as in the interrelationships between children and parents.

A full report of the study will be published in the near future.

Adoptions

Termination of parental rights by judicial proceedings in all adoptions except those of close relatives is one of the major recommendations in a document, "Legislative Guides for the Termination of Parental Rights and Responsibilities and the Adoption of Children," soon to be published by the Children's Bureau. The guides present principles for legislation as well as suggested language for State laws providing judicial proceedings for termination and adoption.

Among the recommendations concerning termination are:

- Provision should be made for both voluntary and involuntary termination.
- Grounds for involuntary termination should include: (*a*) abandonment of the child; (*b*) substantial or repeated neglect; (*c*) mental incapacity on the part of the parent, with poor prognosis. Abandonment is defined as "lack of parental effort to maintain the parent-child relationship"; neglect as lack of proper parental care necessary for the child's "health, morals, and well-being."
- Termination procedures should be held in a court which also has jurisdiction over guardianship, custody, adoption, support, paternity, divorce, and other family litigation. Such courts should have social casework, psychological, and psychiatric services readily available.
- Social studies should be required as a part of all termination proceedings.
- The general public should be excluded from termination hearings, and parents who have executed a waiver should not be required to appear.
- Whenever the court decrees termination, it should appoint a guardian of the child's person and fix responsibility for the child's support.

Among the recommendations concerning adoption are:

- A termination decree should precede the adoption petition in all adoptions of nonrelatives.
- In nonrelative adoptions the child must have been placed with the petitioners by a social agency prior to the petition.
- Social studies should be required by the court in *all* adoptions.
- The adoption hearing should not be held until the child has lived in the petitioner's home for 12 months, though flexibility should be provided for exceptional circumstances.
- The adoption decree should be effective from the date it is filed.
- In cases where the adoption petition has been denied or withdrawn, the court, or another appropriate court, should provide for the child's legal custody, and, if necessary, guardianship.
- No abrogation or annulment of the adoption decree should be permitted.

. . .

In Maryland a 25-member committee, composed of representatives of public and private adoption agencies, civic organizations, physicians, lawyers, clergymen, and educators, is reviewing the State's adoption law with the view of recommending needed changes to the 1963 legislature.

In the 5 years since it was created by the Maryland State Department of Public Welfare to stimulate improved adoption practices in the State, the committee, known as the Maryland Adoption Committee, has devoted considerable effort to spreading an understanding of adoption laws and services among the professions most likely to become involved. Recently it established an adoption resource exchange through which agencies can register families seeking children and children available for adoption. Among its other undertakings has been the preparation of a file folder on adoption which is distributed to thousands of clergymen, lawyers, and physicians, and other persons throughout the State; the preparation of a kit for the use of adoption agencies in the recruitment of Negro adoptive homes; and the publication of a pamphlet on services to unmarried mothers.

The committee members either individually or through subcommittees also work with their own professional organizations to further an understanding of the problems involved in adoption. For example, a committee of the clergy has prepared a pamphlet, "Adoption and the Clergy," for distribution to clergymen throughout the State.

. . .

A project to stimulate the adoption of some 300 children of minority groups—Negro, Indian, Mexican, and Oriental—is underway throughout Minnesota under the aegis of the State department of public welfare. Cooperating are the 87 county welfare departments, the 14 licensed adoption agencies, and the community welfare councils of Hennepin County and St. Paul.

Unmarried Mothers

A 4-year project focused on young unmarried mothers is underway in one of New York City's overpopulated, low-income districts, to gage—through demonstration, service, and research—the potential of intensive social work for their rehabilitation. Launched in 1960 by the New York City Department of Health, the project is steered by an 11-member interdisciplinary committee of department officials. Its plan calls for providing social and health services to a group of not more than 125 unmarried mothers; and for giving the usual health care including public health nurse counseling and referrals to a like number of controls. Intake is limited to unmarried mothers under 21 years of age residing in the East Harlem district, in first pregnancy or with a first child not over 6 months of age.

For the project's first 3 years, concentration will be on services; for the fourth, on assessing the social adjustment of the controls, as well as of those served. Included throughout is a cultural study of the community, which, together with the case studies is designed to deepen understanding of the girls' living patterns and value orientations.

In a preliminary run of the project from June to October 1960, interviews were held with 34 unmarried mothers representing all young unmarried mothers who brought their first babies to child-health stations in that district. All but one were responsive to help.

The project was stimulated by a number of previous studies on unmarried mothers including, in addition to the two studies reviewed on page 184 of this issue, a pilot study in East Harlem carried out by the New York City Department of Health during December 1959 and January 1960.

Child Welfare

Foster parents in Anchorage, Alaska, caring for children brought into that city for medical attention under the maternal and child health and crippled children's services, have collaborated with the Alaska State Department of Health and Welfare in preparing a manual to guide new foster parents with such responsibilities.

Under the direction of the department's medical social consultant, the parents helped collect and sort the material, reviewing it critically and enriching it with ideas, on the basis of their experiences. Although accenting medical and emergency instructions and facilities, the manual also has sections on placement procedures, foster-care payments, sources of needed clothing, and facts to be reported to the department.

Indirect gains attributed by the department to the conferences between the parents and official staff during production have been a clarifying of communication channels and a closer rapport between the parents and the agency, leading to more comprehensive and coordinated care for the foster children.

• • •

The rising number of tall apartment buildings in London's municipal housing developments recently stimulated a group of English women "health visitors," the Women Public Health Officers' Association, to look into the way these multistory dwellings meet the play, safety, and health needs of the child from 2 to 5 years of age. Interviewing a cross-section of mothers with children in this age-span living in such apartment houses within 12 recently built municipal developments, they found that most of the families showed concern about satisfying the children's play needs and were worried about the children's safety. But relatively few families recognized any adverse effect of this way of life on their own or their children's behavior.

In their report, "Two to Five in High Flats," the investigators comment on the frequently heard statement "He played in the apartment all day yesterday," by observing that, deficiency in the kind of play important during preschool years—with other children, with earth and water, and with physical exertion outdoors—cannot be made up later and is likely to show up in character development and outlook on life. They draw the attention of the city's housing authorities to the needs of young children for play equipment, safety measures, nursery schools or supervised play, and outdoor exercise. The report in pamphlet form is available from The Housing Centre, 13 Suffolk Street, London SW. 1; price 3 shillings.

The Mentally Retarded

The Utah Legislature has appropriated $200,000 for continuation of the State welfare department's program of day-care and training centers for mentally retarded and multiply handicapped children. The act authorizing the department to establish the program was passed last year. Five centers have been opened under the supervision of the department by parents' groups and other voluntary organizations with the use of State and voluntary funds, and two more are expected to be opened soon. The centers are available to children of any age and any type of handicap who "cannot benefit from an established public or private school educational program." Their standards are set by the welfare department in cooperation with the State education and health departments, and the Governor's Advisory Committee.

Other States providing public funds for day-care centers for the mentally retarded are Delaware, where the program is under the department of mental health, and Massachusetts, where the program is cosponsored by the State department of mental health and the Massachusetts Association for Retarded Children.

Health Research

The fact that screening children for hearing loss does not reveal all abnormal ear conditions that need treatment or that have predictive value was demonstrated in a study of the relationship between hearing levels and otoscopic (visible) abnormalities among 4,067 Pittsburgh schoolchildren in the 5–14-year age group examined between June 1, 1958, and August 30, 1960.

Part of an ongoing longitudinal study sponsored by the subcommittee on hearing in children of the American Academy of Ophthalmology and Otolaryngology and by the Children's Bureau, the investigations were conducted by members of the University of Pittsburgh Schools of Public Health and of Medicine, under the direction Dr. Eldon L. Eagles. The data suggest that hearing levels vary with age, increasing in sensitivity to a peak at 12 and 13 years. Among the 629 children having otoscopic abnormalities, there was a wider range of hearing levels and a greater percentage with lower hearing sensitivity than among the children without abnormalities. But, the investigation revealed that 85 percent of ears with probable chronic serious otitis media would fail to be identified by audiometric screening levels in common use—a finding which the investigators observed indicates a need for a reexamination of techniques for conserving children's hearing.

• • •

The State University of Iowa is in the process of completing a 6-year study of 175 families in which there are children with cleft lips and palates, and 175 matched control families, in which all children are free of clefts.

The study is supported by a grant from the National Institute of Mental Health. Its purposes are to determine whether—

- factors over and beyond the anatomical deviations differentiate the child with a cleft palate from other children.
- the nature and severity of the adjustment problems of individuals with cleft lips and palates are determined in part by the adequacy of the information their parents have, the nature of the adjustment of their parents, and the attitudes and behavior of their parents,

particularly with reference to the cleft and associated problems.

The major part of the study has required the taking of a detailed, coded case history from both parents of each child studied. Approximately 200,000 coded items of information have been obtained from the experimental group families and 150,000 items from the control group families. The questions asked have covered the areas of birth history, speech history, school history, and hearing problems of the child; and the health history, discipline practices marital relationships, home environment, and occupational history of the parents. The children with clefts from the experimental families—ranging in age from a few days to 16 years—have been given medical, dental, and speech examinations.

Comparisons are being made between the experimental and control groups on the responses to interview items. Intragroup comparisons of the experimental group are also being made, to determine the effects of such factors as the type of cleft, the severity of the speech problem, the age and sex of the child, and the parents' intelligence on family attitudes and interpersonal relations.

The data analyses are scheduled to be completed by August of this year. The study will eventually be published in book form. It is being carried out by D. C. Spriestersbach, professor of speech pathology.

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A 10-year study of B-hemolytic streptococcal infections in 3,000 children has recently been completed in Rochester, N.Y. The study was conducted by three pediatricians, Drs. Burtis B. Breese, Frank A. Disney, and William B. Talfey. The study shows, over this period, that one-fourth of the children had only one attack of streptococcal infection; the other three-quarters of the children had more than one attack. Penicillin was used to treat the infection. The largest proportion of infections occurred in children in the first 2 years of school; infections decreased in frequency as the children became older. Thus, concluded the investigators, immunity to streptococcal infection may be developing despite the extensive use of penicillin in treating these children.

. . .

Even though brain-damaged at a very early age, a rat raised in a rich environment will do better in problem solving than his normal brother raised in a poor one, according to Sol Schwartz, a doctoral candidate in psychology at the University of Michigan. His research with hooded rats—an artificial breed of the black rat, having a white body and black head—has the goal of helping to produce a clue to the relationship between the upbringing of brain-damaged children and their performance in problem solving.

. . .

The National Association for Mental Health recently set up a foundation to conduct its research activities. The new unit, called the Research Foundation of the National Association for Mental Health, allocates grants for inquiries into the causes, prevention, treatment, and cure of mental diseases and provides fellowships for medical students interested in such research.

Guides and Reports

RECRUITING FOR SOCIAL WORK. Elizabeth R. Jacobs. National Association of Social Workers, Medical Social Work Section, 95 Madison Avenue, New York 16. 1961. 72 pp. $1.25; 10-percent discount for 10 copies or more.

Designed for use in the broad field of social work, this handbook offers ideas on surveying the shortage of social workers in a community, finding prospects, training recruiters, and developing and using techniques for "putting the message across."

FOOD BECOMES YOU. Ruth M. Leverton. Dolphin Books, Doubleday & Co., Garden City, N.Y. 1961. 160 pp. 95 cents.

A paperback edition of a popularly written guide to good nutrition (first published in cloth in 1960 by the Iowa State University Press) which in addition to general information on food values contains information on the nutritional requirements of expectant mothers, of babies and young children, and of teenage boys and girls.

THE MOTHER WHO WORKS OUTSIDE THE HOME. Violet Weingarten. Child Study Association of America, 9 East 89th Street, New York 28. 1961. 28 pp. 40 cents. Quantity rates available upon request.

Advises the mother who is in a dilemma about taking an outside job to base her decision on the kind of job sought, what it will do to or for her, the needs of her children, their ages, her physical stamina, and the way her whole family feels about her working.

WHAT WILL HAPPEN TO MY CHILD; some suggestions for parents who are concerned with providing lifetime protection for a retarded son or daughter. National Association for Retarded Children, 386 Park Avenue South, New York 16. 1961. 10 pp. 10 cents.

Offers information to parents of retarded children on how to arrange for the protection of these children after their own death, in relation to legal status, as well as to wills, trusts, social security, and life and other insurance.

THE USE OF MUTUAL SERVICE HOMES FOR UNMARRIED MOTHERS. Katherine D. Lovell and Helen A. O'Rourke. Children's Services of Cleveland, 1001 Huron Road, Cleveland, Ohio. 1961. 19 pp. Limited quantity free on request.

Describes a plan for the unmarried, prospective mother who prefers to live with a family—as a mother's helper—rather than enter a maternity home, covering such aspects as the criteria for matching the homes with the unmarried mothers; medical care; supervision; and followup.

BOOK NOTES

THE FAMILY—A FOCAL POINT IN HEALTH EDUCATION: The Eastern States Health Education Conference, under the auspices of the New York Academy of Medicine. Iago Galdston, M.D., editor. International Universities Press, New York. 1961. 216 pp. $3.

Based on the conviction that health education to be effective must be geared to the dynamics of the family, the 12 papers of this volume throw light on the American family from varying perspectives—structural, psychological, ethnic, and anthropological—and from the angles of education for personal and familial living and for parenthood.

Underscored are the pervasive influences on health and health practices of cultural and social class factors. Examples include the case of an Irish-Italian marriages in which the clash of cultural values leads to the marital partners' developing different, distinct sets of somatic difficulties that wax and wane in "seesaw" relationship to each other. Another paper cites the tendency among members of the lowest socioeconomic groups to prefer, when sick, nonmedical care and advice—from chiropractors and even druggists—and to participate less than others in immunization campaigns.

The contributors include teachers and practitioners of medicine, psychiatry, public health, social work, sociology, anthropology, and statistics.

THE PSYCHOLOGY OF CHARACTER DEVELOPMENT. Robert F. Peck; Robert J. Havighurst; with Ruth Cooper, Jesse Lilienthal, and Douglas More. John Wiley & Sons, New York. 1960. 258 pp. $6.50.

A scientific approach to designing a system of ethics is foreseeable, say the authors, as a corollary of broadened studies in moral-character development, along the lines of studies reported in this book.

Dr. Peck, professor of educational psychology at the University of Texas, and Dr. Havighurst, professor of education at the University of Chicago, in collaboration with the other authors, applied psychological methods—ranging from interviews and formal objective tests to sociometric and projective tests—to "a typical American" group of children over a number of years. The goal was to identify the underlying elements in the personality that govern regularity and stability of moral behavior.

Defining basic character into five types on a scale of maturity—amoral, expedient, conforming, irrational-conscientious, and rational-altruistic—and classifying the subjects according to dominant type, they found that leaders selected by their peers tended to belong to the rational-altruistic group.

An ethical system based on this group's qualities, including empathy, insight, and moral stability, would satisfy the universal needs of man as a social being. The science of behavior, they maintain, is comparable to arithmetic in its regularities and predictabilities.

Since "a child's character is . . . almost the direct reproduction of the way parents treated him," the authors believe a rational ethical theory should consider this pattern of character transmission by providing for the exercise of both intellect and nonrational emotion. They also recommend that schools teach children to reason about behavior, on the basis that it is just as important as reasoning about numbers, language, and machinery.

Initial chapters on the theoretical bases, setting, subjects, and procedures of the studies are followed by findings, with 22 tables, and a 51-page appendix including definitions of technical terms.

NUTRITION AND FAMILY HEALTH SERVICE. Linnea Anderson and John H. Browe, M.D. W. B. Saunders, Philadelphia. 1960. 287 pp. $5.

A collaborative effort of a nutritionist in a school of nursing and a physician in a public health agency, this book offers the nurse "some guidelines and suggestions which may be useful to her in the application of the principles of nutrition and related sciences to the teaching and counseling of families and individuals in their homes."

The first of the book's three sections suggests methods of appraising family food practices—with recognition of cultural factors—and develops guidelines for an effective working relationship between nurse and nutritionist.

The second section deals with aspects of nutrition, such as emotional and psychological factors. Separate chapters are devoted to the general food needs of the expectant mother; the infant and preschool-age child; the school-age child; the adolescent; and the adult.

Describing diabetic and sodium-restricted diets, the third section considers elements essential in modification of any diet: knowledge of the nutrient values of foods as they apply to the specific modification; an understanding of and sensitivity to the needs of the patient; close and continuous communication between nurse and physician; and the need to involve the patient in the planning of his modified diet pattern.

BRING FORTH THE CHILDREN; a journey to the forgotten people of Europe and the Middle East. Yul Brynner. Photographs by Inge Morath and Yul Brynner. McGraw-Hill, New York. 1960. 155 pp. $4.95.

Written around a series of photographic vignettes of refugees met by the author during a United Nations assignment, the text carries a plea for world concern for the children growing up in and knowing only the "half-life" of the camps.

The material was gathered by the author as Special Consultant to the High Commissioner for Refugees, in camps of Germany, Austria, Jordan, and the Gaza Strip, during World Refugee Year. The photographs—some accompanied by only a dab of commentary—and the text, hammer out a central theme: If not rescued before a certain stage of growth, many refugee children show apathy and other signs of withdrawal. Suggested steps for the rest of the world (which in his opinion, must share the blame for the refugees' plight) include providing decent homes, jobs, and education so that the camps can be closed.

IN THE JOURNALS

Family Life in Transition

"Today the family is 'outer-directed' rather than 'inner-directed,'" says Warren T. Vaughan, Jr., M.D., in the July 1961 issue of the quarterly, *Mental Hygiene*. ("Children in Crises.") The author is director of the Mental Health Training and Research Project for the Western Interstate Commission for Higher Education, Boulder, Colo. He maintains that the current tendency to let extra-familial roles take precedence over roles related to family well-being as a whole threatens the stable, secure, and emotional home life necessary to prepare a child for adulthood.

Coupled with this family crisis, he asserts, is a crisis in values—also a result of rapid social change—which is "affecting the mental health of children about us every minute of the day." He stresses the need for community agencies and institutions to develop services based on what is known about child growth and development, and to direct them not only to growing children but also to their parents.

The disturbed child of today, says Dr. Vaughan, cannot be helped by the old-fashioned methods which rely on the secure home and a mutual agreement between school and home, nor will a piecemeal approach to his problems work. What is required, he says, are preventive, diagnostic treatment, and rehabilitation programs developed on a teamwork basis involving representatives of all segments of the population, particularly the leaders of the community. Such programs, he adds, must incorporate research from the outset so that new ways will be found of approaching the problems which each family member faces in the midst of rapid changes in patterns of family living and values.

Focus on the Family

A design for family diagnosis and treatment, currently being tested by participants in the Midwest Seminar on Family Diagnosis and Treatment, is described in *Social Casework* of July 1961. ("The Midwest Seminar on Family Diagnosis and Treatment.") According to the authors, Otto Pollak, professor of sociology at the University of Pennsylvania, and Donald Brieland, director of children's services, Illinois Department of Public Welfare, the design is the product of the first year of the 3-year seminar, held with the goal of increasing the caseworker's understanding of family dynamics.

The design stresses the need for understanding the roles of parents and children both inside and outside the family group, since a child's behavior mirrors combinations of behavior models from many persons, and since the interactions of all family members with others in the community may have psychological significance.

Because of the complexity of family interactions, the caseworker is advised to use "relevance" as a measure for selecting the data for use in identifying the family's most burdensome problem constellation; and next to look for the ways this is expressed in a breakdown of interpersonal relationships, as well as for strengths and signs of cooperation within the family. Whether the causes of the breakdown are still operating and can be controlled are stressed as two central treatment concerns.

Coming to the Migrant

To keep migrant laborers from becoming "victims of their own efforts to find jobs," public and private social agencies must extend and adapt their services to the needs of the migrant's families and children, writes Marion L. Sheridan in the July 1961 issue of the quarterly, *Public Welfare*. ("Adapting Services for Migrant Children.") The author, who is head of the Office for Children and Youth in the Pennsylvania Department of Public Welfare, points to Pennsylvania's example in promoting and operating day-care centers, employing social workers, and augmenting staff and clinic hours at the child health centers for 3 months of each year during peak use of migratory labor.

Pinpointing the basic service needs of workers in "blue-sky sweatshops," she suggests setting up a central intake and referral service for families needing services; counseling and guidance services for parents; a centrally located day-care center for children over 3 years of age with convenient hours and adequate transportation; and for children under 3 years, in-camp care through mutual agreements or arrangements with one woman, or foster care in surrounding communities.

When such services are available to itinerant farmworkers, they must be told so, concludes the author, advising social workers to spread the word.

Learning by Doing

During the summer of 1959, 23 high-school students and 1 college student worked as volunteers in the Baltimore City Health Department, contributing 2,550 hours of work, for which the department's cash outlay was $32.11 for the 10 weeks. The program is described in *Public Health Reports* of August 1961, by the city's health commissioner, Huntington Williams, and two department officials, Ann Miller and Joseph Gordon, who tell of recruiting the volunteers through public school personnel, the American Red Cross, and a local hospital; of holding orientation sessions with the participation of department staff and student volunteers; and of assigning the students to tasks related to public health nursing, child hygiene, and medical care, and in laboratories. ("Use of Teenage Student Volunteers in a Local Health Department.")

The project was continued during the summer of 1960, when 28 students contributed 2,070 hours. It needs some refining, say the authors, in relation to deciding whether criteria for selecting the volunteer should reflect the interests of the department or the volunteer; making the assignment according to the special aptitudes of the student's age group; and modifying the task for more appeal to the young person.

Cystic Fibrosis

Corroborating clinical observations that cystic fibrosis of the pancreas "is not the uniformly fatal disease of infancy or early childhood that it was formerly considered to be," a study reported in *Pediatrics* of July 1961 indicates that of the estimated 2,500 patients hospitalized in the United

States in 1957 for this hereditary condition, about 10 percent were aged 10 to 20 years and a smaller percentage, 20 years or older. ("Characteristics of Patients With Cystic Fibrosis Discharged from Hospitals in 1957: Estimates for the United States," by Elizabeth R. Kramm, Marian M. Crane, M.D., Morton L. Brown, and Monroe G. Sirken.) The data are drawn from a national hospital survey of cases, the first ever done on a broad geographical scale for this disease. (See CHILDREN, July–August 1959, p. 155.) The survey is part of a series designed by the Children's Bureau and the National Office of Vital Statistics, U.S. Department of Health, Education, and Welfare, to investigate the magnitude of the health problem presented by this condition.

Underscored among other findings are the following:

- Most of the cases (70 percent) were in hospitals in the Northeastern and North Central States, and only 9 percent in the West, during 1957.
- Roughly 4 children per 100,000 persons under 21 in the population were hospitalized for the disease in the year. Rates per 100,000 children in various age groups were about 8 patients among children under 5; about 3 among 5- to 9-year-olds; and about 1, among the 10- to 20-year-olds. Among infants, 18 were hospitalized per 100,000 live births in 1957.
- About 85 percent of the cases were under 10 years of age and about 30 percent were infants.
- Almost 15 percent of the 2,500 patients died in the hospital that year. Almost 40 percent of these were infants, about 25 percent were 1 to 4 years old, and about 25 percent, 5 to 9. Although more males than females were hospitalized for the disease, a higher percentage of females under 10 died than of males.
- At least a third of the 2,500 patients had had multiple admissions for the disease.

Pinpointed as needing future study are the elements contributing to regional variations in prevalence. Suggested as possible factors were differences in physicians' familiarity with the disease, availability of diagnostic facilities, racial predilection to the condition, and the movement of families with fibrocystic children to areas where specialized treatment is available.

READERS' EXCHANGE

MEYER: ***Staff development***

Carol H. Meyer describes the staff development project of the New York City Bureau of Child Welfare as a demonstration project. ["A Development Program for Child Welfare Staff," CHILDREN, July–August 1961.] However, her article does not make clear whether the goal is to set up a permanent position of director of staff development, or whether at the close of the demonstration the supervisory personnel now being groomed as training supervisors are expected to carry on with the blessings of the administration. If the latter is the case, I am skeptical of the outcome.

As an "old hand" in staff development, I have lived through a number of administrative changes with resulting shifts in responsibility for staff development. This has left me with a strong conviction that one person must be charged with the leadership of the staff development program, although all levels of staff must be involved. Both administrative and supervisory personnel are bound to be affected by the phenomenon common to all public agencies—pressure. With decentralized leadership, the staff development program is whittled away here and there "to adjust to emergency," until little is left.

One of the discouraging aspects of the problem in the New York City agency is staff turnover. Miss Meyer did not state what processes of selection the agency uses. To be constantly orienting new staff "composed of persons whom we are never sure will remain" is costly and defeating of the goal of providing opportunities for growth to all staff. In our agency we have often found that "drawing the belt a little tighter," while we wait for properly qualified staff, pays off. In fact, general awareness of the agency's requirements has led many desirable candidates to our door.

Miss Meyer mentions a stipend program involving 20 or 30 persons a year. Since she does not mention how long the program has been in effect, we do not know whether the 57 fully trained workers on the agency's social service staff of 548 persons represent the harvest of a new program, or whether it reflects high turnover of professionally trained workers. It is doubtless an overwhelming problem to build a trained staff in New York with its many tempting professional opportunities. In my opinion, however, more concentration of funds and effort in this direction would more quickly bring the agency to the achievement of the goal of staff development—effective services to children.

I recognize my own rashness in making suggestions without knowing the particular administrative problems involved. I believe, however, that with the use of Federal funds and with good administrative planning, a public child welfare program can develop a professionally trained staff within a comparatively short period of time. Within the past decade, I have witnessed the growth of fully trained staff in my own agency from a mere handful to approximately 70 percent, with all the supervisors in our direct service program fully trained and experienced.

To build a professional staff, the following steps are necessary:

- Gearing the size of the stipend program to anticipated agency needs.
- Selling the need for effective services to the public so that salaries will be commensurate with training.
- Providing opportunities for advancement in accordance with demonstrated knowledge and skill.
- Providing good working conditions sound personnel practices, and fringe benefits.
- Differentiating responsibilities so that trained workers will find professional satisfaction in their jobs.
- Providing good supervision, staff development opportunities, and consul-

tative services to all of the personnel.

- Studying staff turnover and taking whatever administrative steps are necessary to eliminate remediable causes.

Such a program will not immediately eliminate the need for the program Miss Meyer has so ably initiated, but it will bring the objective into much shorter range.

Mary L. Schuster
Staff Development Consultant, Division for Children and Youth, Wisconsin State Department of Public Welfare

ACKERMAN: *Problem of complexity*

Two of Dr. Ackerman's outstanding contributions to research in family diagnosis and family therapy are his continuity of concern and his courage in therapeutic intervention. ["Family Study and Treatment," by Nathan W. Ackerman, M.D., CHILDREN, July–August 1961.] Anxieties of damaging the patient or at least of imposing the values of the therapist upon him are powerful factors in producing many "noninterventionists" among psychiatrists and social workers. But Dr. Ackerman's efforts also present problems to the therapists who would like to respond positively to the stimulation they provided.

First, there is the problem of complexity which family diagnosis and therapy present to the practitioner by unavoidably broadening the range of factors to be considered. Complexity calls for conceptualizations to make the diagnostic and therapeutic task manageable. In this regard, Dr. Ackerman's writings, as well as the writings of many others who come from traditional training in psychiatry and social casework, present a self-defeating fusion of concepts which belong to different levels of abstraction. The frequently used dichotomies of "individual and family," "individual and environment," and "psychotherapy and social therapy," present a never-failing trap to perception. In relation to program, they seem to guarantee completeness of perception. In reality, however, they not only permit, but actually force, concentration of perception upon the individual patient and upon psychotherapy.

Thus we find in Dr. Ackerman's paper a reference to the child as the "primary patient." Such terminologies represent attempts to justify a combination of comprehensive orientation to the family with a fractionalization of the family in treatment. They represent rationalizations for the limitation of therapeutic input into a situation.

What is overlooked is the impact upon the family. In the family in which one child is treated as the primary patient, his parents are treated as secondary patients and probably are aware of this. Siblings often remain outside the therapeutic orbit altogether. In a family in which one of the two spouses is treated as a significant parent, the other is treated as, and probably made to feel like, an insignificant parent. In such situations resentment against the family member singled out for therapeutic consideration or for "significance" is built up.

Thus negative reactions within a family to therapeutic gains made by one of its members are due not only to the threatening of the neurotic satisfactions derived by the others from his pathology, but also to the hostility against him and the therapist which such treatment concentrations stimulate. Dr. Ackerman's well-taken point that fractionalized therapy leaves other pathologies unattended does not seem to me to tell the full story. Fractionalized therapy also creates new conflicts and the therapists, if not their creators, are at least their stimulators.

Secondly, active intervention as a treatment method requires not only differential diagnosis of the patient but also differential diagnosis among therapists. Different types of intervention will have to be tested in family therapy for their appropriateness in specific family situations, and not every therapist will be able ot perform all of them. This raises the problem in supervision of concentrating more on appropriate assignment than on training efforts intended to make a therapist for any situation out of a person suited by personality to intervene only in specific types of situations. Experimentation with assignment and supervision now in process at the Jewish Family and Community Service in Chicago may lead the way in this respect.

Finally, in order to equip himself fully for the task of family therapy, the therapist will have to be on the lookout not only for family conflict and, as Dr. Ackerman appropriately suggests, for health roles as well as for sick roles, but also for family goals—an untapped area in family therapy. Immediate treatment goals to relieve the acute discomfort and conflict within the family operate against the perception of socially adaptive and ego-supportive family goals. If in his searching in the past the diagnostician is on the lookout for potential as well as for causes of discomfort, he may discover experiences and concerns which could provide a community of aspiration among the family members. If family therapy is then interpreted ot the family as a method of increasing the capacity not only to cope with conflict but also to achieve family aspirations, it may find friends in those members who are not singled out for individual attention.

Otto Pollak
Professor of Sociology, University of Pennsylvania.

CASE CONFERENCE: *More comments*

I should like to make some comments on the case story presented in the "Case Conference" in the May–June 1961 issue of CHILDREN.

In a brief case summary of this type, obviously all the pertinent information about the family cannot be included. Several questions come to mind:

- I wonder where their relatives, besides the 65-year-old grandmother, are. Don't they have any?
- Does the family have any close friends, or have they alienated themselves from others rather completely?
- The social worker at the child and family agency accused Mrs. A of lying. Has this been her experience with people generally?

The case may be even more difficult than it appears if the family distrusts those who might be able to help. In addition to joint planning by the various agencies which might be involved, it would require considerable work by one single individual working with this family in helping them to feel sufficient confidence to accept any program which is planned. This might be a social worker or a public health nurse. Helping Mrs. A to receive the obstetrical care which she needs immediately would certainly be an excellent beginning!

Malcolm L. Rosenblatt, M.D., Bay State Medical Associates, Boston, Mass.

U.S. GOVERNMENT PRINTING OFFICE: 1961

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Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

HEALTH STATISTICS FROM THE U.S. NATIONAL HEALTH SURVEY: selected health characteristics by area. United States, July 1957–June 1959. Department of Health, Education, and Welfare, Public Health Service. PHS Publication No. 584—Series C6. March 1961. 44 pp. 35 cents.

On the basis of household interviews covering a sample of about 235,000 persons throughout the Nation, this publication presents statistical data on limitation of activity, disability days, chronic conditions, persons injured, and physician and dental visits, for the nine geographic divisions and for each of the eight largest standard metropolitan statistical areas. These are Boston, New York-northeastern New Jersey, Philadelphia, Pittsburgh, Detroit, Chicago, Los Angeles, and San Francisco.

ON BECOMING A JUVENILE COURT JUDGE. William H. Sheridan and Pat O. Mancini. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Series "Work With Children Coming Before Courts," No. 1. 1961. 20 pp. 15 cents.

This is the first in a series of nontechnical pamphlets written to aid in orienting new staff to the problems involved in working in the field of juvenile delinquency. It describes the type of information and relationships to staff, police, attorneys, and community a juvenile court judge needs to have to proceed according to the best interests of the child coming before him.

1960 SURVEY OF SALARIES AND WORKING CONDITIONS OF SOCIAL WELFARE MANPOWER; highlights and preliminary tables. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance and the Children's Bureau. 1961. 36 pp. Single copies free on request.

This report presents the preliminary findings of a study made by the Children's Bureau and the Bureau of Public Assistance as part of a comprehensive survey of salaries and working conditions of social welfare manpower in the United States in 1960, conducted by the Bureau of Labor Statistics, U.S. Department of Labor, in cooperation with the Department of Health, Education, and Welfare, and the National Social Welfare Assembly. (See CHILDREN, July–August 1961, p. 153.) It includes information on all social welfare workers in federally aided public assistance and child welfare programs in all the States.

ILLEGITIMATE BIRTHS: UNITED STATES, 1938–57. Joseph Schachter and Mary McCarthy. Department of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics. Vital Statistics—Special Reports, Selected Studies Vol. 47, No. 8, Sept. 30, 1960.

This report presents data collected by the NOVS on births out of wedlock in the United States from 1938 through 1957. The data are based on information gathered from the birth certificates of various States, with tables and graphs presented to show detailed characterics such as color, age of mother, and place of residence, and changes in the number and rate of illegitimate births in the prewar years, during World War II, and in the postwar period.

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Page 171, New York City Youth Board.

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Next Steps Against Polio

A Cystic Fibrosis Program

Helping Unemployed Youth

Effects of Maternal Employment

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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◀

A CHILD'S HAVEN is his mother's lap. Unfortunately many children are, for various reasons, deprived of the security of the kind of warm, consistent mother love symbolized by this picture. Efforts to help foster parents to achieve the skills necessary for giving these children the "plus" in care and understanding required for erasing the emotional scars of such deprivation are described in the article beginning on page 218.

◀ *the authors*

Dr. Alexander D. Langmuir has been chief of the Public Health Service's Communicable Disease Center in Atlanta since 1949. Previously he was associate professor of epidemiology at Johns Hopkins University. He has also been consulting epidemiologist for the U.S. Army, deputy commissioner of health for Westchester County, N.Y., and physician for the New York State Department of Health.

Victoria Shannon has been in her present position for the past 10 years. Previously she was with the Vanderbilt University Hospital in Nashville and in the Montgomery County (Md.) Health Department. She has written extensively on cystic fibrosis. Her last article in CHILDREN was on the problems faced in informing parents of a child's congenital defects. (January–February 1955.)

Psychologist Saul S. Leshner, left, worked in personnel and vocational counseling for industry, the U.S. Government, and the University of Pennsylvania before becoming head of Philadelphia's JEVS in 1951. Anthropologist George S. Snyderman, right, who joined the agency this year, has worked in various supervisory and counseling capacities for the State and U.S. Employment Services.

Since receiving her master's degree from Ohio State University, Carolyn Thomas has concentrated on work with children in their own and in foster homes. She was in the foster home department of the Family and Children's Service of Greater St. Louis when she conducted the experiment here described. She has also been a caseworker on the staff of the Children's Bureau of Dayton, Ohio.

Marian Radke Yarrow, psychologist, has been with the National Institute of Mental Health since 1953, conducting research in the development of children's social attitudes. Previously she was with the University of Minnesota's Institute of Child Welfare. She is at present President-elect of the division of developmental psychology of the American Psychological Association.

Before going to Stanford University, where she teaches a course in child development, Eleanor Maccoby was a lecturer at Harvard University's department of social relations. Coauthor with R. R. Sears and H. Levin of the book "Patterns of Child Rearing," she has also written previously for CHILDREN. ("Children and Working Mothers," May-June 1958.)

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Killed and live virus vaccines and their part in . . .

NEXT STEPS IN POLIOMYELITIS CONTROL

ALEXANDER D. LANGMUIR, M.D.
Chief, Epidemiology Branch, Communicable Disease Center, Public Health Service

THE CONQUEST of poliomyelitis has been one of the great public health events of the mid-century. The campaign is progressing well but is not yet won. Experience over the past 7 years since the development and licensing of the first poliovaccine in 1955 provides a sound basis for outlining the next steps that must be taken to achieve the goal of the elimination of the disease.

The first poliovaccine was developed by Dr. Jonas Salk and consisted of a suspension of virus particles for the three separate polioviruses—Types I, II, and III—which had been inactivated, that is, rendered noninfective, by careful treatment with dilute concentrations of formalin. Although commercial production of a satisfactory vaccine of this type in the first year presented some difficulties, these were soon surmounted and the vaccine has since been widely used in this country and abroad. Over 90 million Americans have now had at least one dose. Among those who have had four or more doses, properly spaced, it has proved up to 90 percent effective in preventing paralytic polio.

During this same period another kind of vaccine has been under intensive research and development in this country and many other parts of the world, particularly Russia. This vaccine consists of live but attenuated strains of poliovirus that have been artificially selected and modified in the laboratory to lose their virulence. They are fed by mouth and hence are referred to as oral poliovaccines. The names of Drs. Hilary Koprowski, Herald Cox, and Albert Sabin and many others are associated with the development of these vaccines. The Sabin strains have been selected for production of oral vaccine in the United States and are also the ones most widely used in other countries.

The oral vaccines offer great promise for accelerating the campaign against poliomyelitis. They have the distinct advantage over the formalin-inactivated vaccine of ease of administration; a few drops on the tongue or on a lump of sugar or in a teaspoon of syrup is all that is required. They act promptly and are believed by many scientists to confer a more effective and lasting immunity. They are particularly suitable for use on a mass basis.

Problems have been encountered, however, in the consistent production of these vaccines. The manufacturing process is extraordinarily complex. The standards of safety, purity, and potency required by the Public Health Service before licensing is permitted are rigid. Only in August of 1961 was the first license granted for the sale of Type I oral vaccine. Release of the other two types can be anticipated soon.* At the present time, however, an interim period has begun when all who are actively concerned with the control of poliomyelitis will be faced with problems in deciding the immediate next steps to be taken.

The present paper will consider some of these problems. The broad epidemiological experience over the past 7 years will be reviewed for guidelines to future action. What should our next steps be? What should our plans be when all three types of oral vaccine become available? What basic requirements can be set for the elimination of the disease and for maintaining its absence permanently?

---

*A license for Type II oral vaccine was granted in October 1961.

The experience since 1955 clearly shows that the present inactivated vaccines have been highly effective. Failure to achieve greater control can be ascribed to our failure to immunize all susceptible groups rather than to inadequacy of the vaccine. The new oral vaccines should greatly facilitate more effective control. The permanent elimination of the disease will require an effective program of immunization of all infants on a continuing basis.

Experience to Date

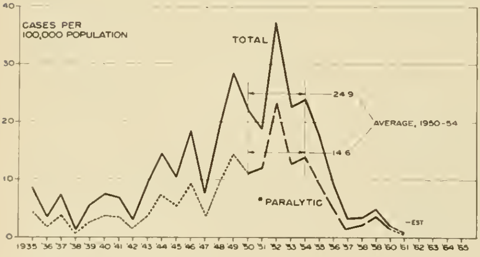
The annual incidence rates of both total and paralytic cases of poliomyelitis are shown in Figure 1 for the period from 1930 to 1961. During the 1930's and before, the incidence of the disease was relatively low. A rising trend began in the 1940's and continued into the first half of the 1950's. In the second half of the 1950's, a steep decline is apparent. This was interrupted in 1958 and 1959, but returned in 1960 and 1961. The total number of paralytic cases in 1961 should be under 1,000 cases, comprising an incidence figure well below any ever recorded since national reporting began in 1912.

The interpretation of a declining trend such as that observed for poliomyelitis in the past 7 years is difficult. One must consider the possibility of long-term cycles. Could the recent decline be the result of some strange epidemiological periodicity of unknown character? Such an idea would suggest that the vaccine program had little or no effect. It would also suggest that poliomyelitis might recur in severe epidemic form during the next cycle.

Figure 1

ANNUAL POLIOMYELITIS INCIDENCE RATES

United States, 1935–1961



* PARALYTIC CASES PRIOR TO 1951 ASSUMED TO BE 50% OF TOTAL

There is no sound basis for such a hypothetical construction. In small population groups such as in single States, or in small countries, epidemics of great severity have occurred in certain years, preceded and followed by periods of relatively low incidence. In large populations such as the whole United States, no cyclical pattern has been manifest. On the contrary, the increasing trends of poliomyelitis in the 1940's and 1950's were part of a worldwide phenomenon related to the advancing standard of living and the increasing birth rate following the great depression. The commonly accepted explanation is that with better housing, suburban living, greater access to soap and water and greatly improved care of infants, the time of first exposure to the ubiquitous polioviruses has been progressively postponed to an age where the risk of developing paralysis is greater.

Nothing has happened in this country during the past 7 years to change these basic ecological relationships. On the contrary, there has been progressive improvement in the standard of living. Hence, a sounder judgment would be to have expected a continuing upward trend in incidence during the late 1950's and early 1960's had no other factor such as a poliovaccine program been introduced to affect the picture.

It is, therefore, conservative to select the 5-year average incidence from 1950 to 1954 as a level of comparison with current figures. This average for paralytic cases was 18,716. In 1960 only 2,292 cases occurred, comprising an 88 percent reduction. In 1961 the experience to date suggests the reduction may be as much as 94 percent.

Concurrently with this declining trend other basic changes in the epidemiological pattern of poliomyelitis occurred. The age of attack changed markedly. From a disease that was afflicting an increasing proportion of school age children and even adults, it began to revert in 1956 to its former infantile character with highest attack rates occurring in 1- and 2-year-old children. There was also an interesting switch in the sex distributions.

A comparison of data for paralytic cases by age and sex in 1955 and 1959 shows that while there is a great overall reduction, a relative concentration among infant and young preschool children remains. In regard to adults, in 1955 higher rates occurred among females, presumably because of their greater susceptibility due to pregnancy and their closer contacts with young people, but in 1959 higher rates occurred among males, revealing their relatively lower levels of immunization. Investigation in several epidemics showed that most of the cases among adult males occurred in unimmunized fathers of small children. These recent age patterns form the basis for the plan developed by the Public Health Service for a nationwide Babies and Breadwinners program to concentrate anti-polio efforts this year on immunizing these specific groups. [See CHILDREN, March–April 1961, page 77.]

Another important change in the epidemiological pattern of poliomyelitis has occurred. Prior to 1956, epidemics commonly spread extensively throughout whole metropolitan areas and beyond. Attack rates were amazingly uniform in all racial and socio-economic groups. If any differences occurred they tended to higher rates among upper income levels. Following the introduction of the inactivated vaccine in 1955, epidemics of poliomyelitis have been sharply concentrated in the lower socio-economic segments of the population. Isolated, crowded, ethnically distinct groups have been selected for attack. For example in the 1959 epidemic in Kansas City, Negroes suffered the highest attack rates ever recorded for Negroes in that city. Among all the epidemics that have occurred since 1956, the one consistent feature has been the relatively low levels of poliomyelitis immunization among the populations attacked.

There is, nevertheless, abundant evidence in the declining trends, the shifts in age distributions and the altered geographic and socio-economic patterns to conclude that the immunization program begun in 1955 and still continuing has been highly successful in effecting substantial control of the disease.

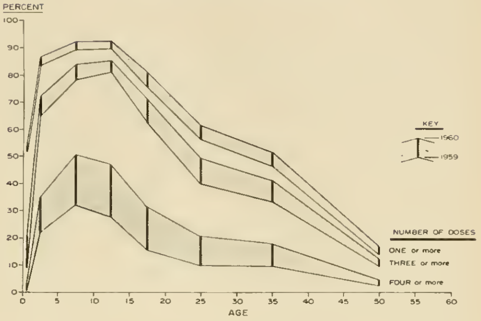
Use of Vaccine

This result has been achieved in spite of the fact that substantial numbers of our population have yet to be immunized. Since 1955, the approximately 400 million doses of inactivated vaccine distributed for domestic use have been given to certain population groups more intensively than to others. In September of each year a survey of polio immunization is carried out by the United States Bureau of the Census. The results for 1959 and 1960 are shown in figure 2 by age group. The highest immunization levels are found among the school-age children—those 5 to 14 years old—but, even in this group, only 50 percent have received the recommended four doses. Most of the preschool children have had some vaccine, but only 35 percent have received four or more doses. The immunization levels among young adults are even lower than those among preschool children.

Figure 2

POLIOMYELITIS IMMUNIZATION LEVELS

By Age and Doses of Vaccine
United States, Sept. 1959 and 1960



Source NATIONAL POLIO IMMUNIZATION SURVEY - SEPT 1959, 1960 (M G SIRKIN, NOVS)

The Interim Period

The implications of these findings are obvious. The program over the past 7 years based on use of inactivated vaccine has been remarkably successful in spite of the failure to reach large numbers of susceptibles in the population. Continued and intensified Babies and Breadwinners immunization programs can be expected to achieve substantial further improvement in control of the disease. In this interim period, before the release of Types II and III oral vaccines, use of the inactivated vaccine is the only available procedure to confer broad immunity to all three types of poliomyelitis virus.

The oral vaccine for Type I, now available, has valuable immediate application both for epidemic control and for feeding to newborns. A portion of the first lots to be released on August 24 was set aside for the Public Health Service's epidemic reserve, and within 24 hours a large allotment was made to the New York State Department of Health for use in controlling the epidemic in Syracuse and surrounding counties. This reserve is available on request of State health officers when three or more cases have occurred in a circumscribed area within a 30-day period, providing at least two cases have been typed. The oral vaccine should be administered promptly to all persons of all age groups residing within an epidemic area. In Syracuse, vaccine was fed over a 3-day period to over 400,000 persons out of a total population of approximately 750,000.

Experience needs to be gained with the feeding of Type I oral vaccine at birth. Although it is known that the response of newborns is only partial, this procedure has been advocated by many as a desirable routine, perhaps to become as universal as silver nitrate drops in the eyes. The ease of administration and the ready accessibility of infants due to the almost universal practice of hospital delivery make this procedure a most attractive proposal from the public health point of view. Practical experience on a progressively larger scale is needed to work out the best methods and to determine the suitable dosage. This can be started now.

Mass Use of Oral Vaccine

When Types II and III oral vaccines are released and adequate quantities of all three types are then available, a new phase in the poliomyelitis campaign will begin. Programs for mass immunization will be sponsored in many, if not all, communities in the country. Such programs have been found to be universally popular in all communities where they have been carried out on an experimental basis.

The justifications for mass programs are several. A large number of unimmunized persons who have up to now resisted needles or who object to the cost will hopefully respond to free clinics. Those who have received inactivated vaccine will have their immunity reinforced. Moreover, the oral vaccine is known to confer local tissue immunity in the alimentary tract and thus should further interrupt the spread of "wild" or virulent polioviruses in the community. If a sufficient proportion of the population is effectively immunized, it is believed that the natural chain of infection of the wild viruses may be wholly disrupted.

It must be remembered that the anti-polio campaign will not be ended after extensive and successful mass immunization programs have been completed. The continuing immunization of infants during their first year of life is of paramount importance; in fact, it is the most fundamental of all aspects of the poliomyelitis control program.

Successful mass programs will certainly achieve a great reduction, if not elimination, of the natural spread of wild strains of poliovirus. Thus, the normal process of natural immunization that has gone on in the past will cease. Infants born into such a situation who are not immunized artificially will become highly susceptible as their maternal antibody disappears. A large number of such children in the population or even small localized clusters of them will be ripe for an outbreak and possibly for an epidemic of greater severity than any experienced in the past. The only protection against such a danger is the successful immunization of all infants. To achieve this will require careful organization on the part of every health department to insure that every new child born into the community has been given the opportunity to be immunized, and to check whether the opportunity has been taken. This will require systematic surveys and auditing procedures based on the use of individual birth certificates for recording immunizations and checking on the immune status of infants as they reach their first birthday.

The time is rapidly approaching when it should become a basic human right for every child born in this country to receive protection against poliomyelitis and all communicable diseases for which vaccines exist. It must be the obligation of every parent to see that such protection is received. It should be the responsibility of the health authority to organize the necessary services to insure that high levels of immunity are maintained.

Conclusion

The campaign for the conquest of poliomyelitis over the past 7 years has shown substantial success. Continued use of the inactivated vaccines is strongly indicated particularly for protection of those preschool children and young parents who have not yet been immunized.

The oral vaccine for Type I poliomyelitis presently available has special application for epidemic control and for feeding to newborns.

When Types II and III oral vaccines are released, mass immunization programs can be anticipated throughout the country. These will reach additional persons not yet immunized with inactivated vaccine and reinforce immunity among those who have already received it. The long-term effective elimination of poliomyelitis depends upon the organization in every community of systematic programs for the immunization of infants during their first year of life.

In Connecticut the crippled children's service calls on a variety of professions and organizations in carrying out . . .

A PROGRAM FOR CHILDREN WITH CYSTIC FIBROSIS

VICTORIA SHANNON

Medical Social Consultant, Crippled Children Section, Connecticut State Department of Health

IN 1954 the Connecticut State Department of Health began to receive inquiries from a variety of sources about the possibility of its crippled children section providing families with assistance in the care of children with cystic fibrosis. These inquiries came from an industrial nurse, parents of children, the head of a city welfare department, a physician at the Yale University medical school and the officers of the Children's Cystic Fibrosis Association of Connecticut, an organization of parents of children with this nearly always fatal impairment, which had been formed that year. By 1955, at the urging of the Children's Cystic Fibrosis Association, the Connecticut General Assembly made its first appropriation for help to children with cystic fibrosis. This was for $25,000 for the biennium. Thus the people of the State gave the State health department their sanction to assume leadership in planning and developing the program. This, of course, was accompanied by accountability to the public—not only the part of the public which is directly concerned with the program, but the entire community as supporters and potential consumers of the program.

Cystic fibrosis belongs in a group of hereditary metabolic diseases.[1] Many or perhaps all of the exocrine glands function abnormally: the exocrine glands chiefly affected are the mucous glands of the bronchi and nasal passages, the sweat glands, and the digestive glands. "The most common clinical results of cystic fibrosis are, therefore, chronic bronchitis, malnutrition, or poor gain, steatorrhea (fatty stools) with loss of fat soluble vitamines, and susceptibility to heat prostration. The respiratory infection produces the most distressing symptoms and is the usual cause of death."[1]

As soon as thought was given to the possibility of developing a program in Connecticut to assist children with cystic fibrosis and their parents, the staff of the State health department's crippled children section immediately reached out to work with others whose understanding and collaboration would be needed in helping these children. Frequent discussions were held about staff and facilities needed for diagnosis and treatment and their costs; the categories of professional persons that needed to learn more about the condition and how they could be reached; what kinds of service the families needed; and how the crippled children section could make the most effective contribution.

Among those consulted were the State medical society, whose committee on public health approved the plans developed; the Children's Cystic Fibrosis Association; the department of pediatrics of the Yale University School of Medicine; and hospitals and physicians both in and outside of Connecticut. A number of conferences were held with members of the administrative, nursing, and social service staff of the Grace-New Haven Community Hospital, as it was obvious that this would be one of the main treatment centers used. Thus the variety of persons who would be directly concerned with the program became involved in determining what services were needed, which ones would be met through the State health department, and what the procedures would be.

When the plan was completed, letters telling about the new services were sent to individual physicians and officers of medical societies, hospital administrators, social agencies, and public health nursing agencies.

The organized parents' group played an especially important part in the initiation of the program. In 1954, this group not only requested the State health department to initiate the program, but also had a bill drawn up and presented to the State legislature asking for appropriations. Sixty families belonged at that time.

The group now meets regularly, usually having outside speakers followed by informal discussions. It continues to support State health department programs by appearing at legislative hearings, gives substantial financial aid to the two clinics in medical centers serving most of the families, provides aerosol equipment for the children, and participates in educational programs designed to acquaint the public and professional groups with the meaning of a diagnosis of cystic fibrosis. Assisted by a labor union, the group gives an annual Christmas party for all the children in member families.

The health department's crippled children section maintains a relationship with this voluntary group, the medical social work consultant who works most closely with the cystic fibrosis program providing the group with information as requested. These requests have been regarded as opportunities to interpret the department's needs and policies.

Description of the Program

The services available under the State's cystic fibrosis program are similar to those given to children with other crippling conditions. The program follows the purposes of the Federal Children's Bureau program for crippled children: to provide skilled medical, surgical, nursing, social, and physical therapy services for children in hospitals, convalescent homes, foster homes, and in their own homes; and to cooperate with other resources in providing and promoting the development of services to crippled children. The program stresses the importance of planning, so that the various services will be provided as they are needed.

The fundamental assumption of the program is that the service should be given in such a way as to tend to increase the possibility of a child's leading a normal life with his family. All children up to 21 years of age who reside in the State are eligible for diagnostic service. Eligibility for treatment is determined by several factors, including diagnosis, lack of other treatment opportunity, the need for a planned program of medical care, and the economic situation of the family, or other social and emotional problems.

The program may assist in the care of children at home by providing medical consultation, laboratory and X-ray service, and some medication. Funds are generally available for hospital care also. Depending upon the need, continuing medical, social, public health nursing, or nutritional consultation services are provided. The parents are encouraged to maintain close touch with their private physicians. Social services are provided, either directly by one of the consultants of the crippled children section or through referral to local community agencies. The nursing service is usually provided by local visiting nurse associations, advised by the nursing consultants in the State department of health. The other services are purchased from existing medical resources. Drugs, prophylactic antibiotics, and pancreatin—a drug necessary in treatment—are sent directly to the patients free of charge on receipt of prescriptions from the physicians.

The staff members in the crippled children section who become involved in the provision of care are, in addition to the physicians, medical social work consultants, nursing consultants, secretaries who

CYSTIC FIBROSIS SURVEY

The Children's Bureau and the National Office of Vital Statistics, U.S. Department of Health, Education, and Welfare, are about to launch an extensive sampling survey of physicians and clinics to determine the incidence of cystic fibrosis in the 17 Eastern Seaboard States and in the District of Columbia. The survey is a major part of a project begun in 1959, with funds from the National Institutes of Health and has been preceded by a recently completed pilot survey conducted in three New England States—Massachusetts, New Hampshire, and Vermont. (See CHILDREN, January–February 1959, page 36.)

The pilot study demonstrated the feasibility of deriving accurate estimates of diagnosed cases by means of the survey method and provided an indication of the magnitude of the cystic fibrosis problem. Its preliminary findings indicate: that the incidence of cystic fibrosis appears to be somewhat less than 1 case per 1,000 live births—the generally accepted ratio; that from 1952 to 1959 the known number of patients had more than doubled; that during the same period, the number of cases detected each year exceeded the number of deaths due to the disease; and that while the same number of deaths occurred in each 4-year period, 1952–55 and 1956–59, there was a significant shift in the percent distribution of deaths to the age group 10 years and older.

A report of the methods and the findings of the pilot study will be published in the near future.

handle incoming and outgoing data, the fiscal officers of the department, who may or may not understand and approve the expenditures being requested; clerks who handle the requisitions for and dispensation of drugs. Members of the advisory committee, administrators of programs and various public officials, including members of the legislature, also become involved.

Postgraduate education of physicians in recognition and treatment of the disease has been encouraged through the program. Educational efforts have also been directed to other professions involved in the care of patients through the organization of meetings for specific professional groups; the writing of informational letters and articles, and the organization of institutes.

A review of the first 5 years of the program shows that 178 children have been referred to it. At present, 93 children with cystic fibrosis are receiving some form of attention from the crippled children section. About one-fourth of these youngsters are under the exclusive care of private pediatricians. Most of the others are under the care of one of the two well-known specialized clinics and local physicians, jointly. As both case finding through examination of siblings and increased knowledge of the program have gone on, children are being referred to the program at increasingly younger ages. However, there are also more older children under care now than in the early days of the program because of the success of new methods of treatment and therefore the patients' longer survival, and because of the more frequent recognition today of mild cases. There has been a decrease in hospitalizations due in part to the use in homes of treatment which was formerly done exclusively on an inpatient basis. Current methods of treatment also appear to have greatly lessened the frequency of severe respiratory infections.

Social Services

At the present time many families initiate their contact with the crippled children section by mail, through 'the use of an application blank, in which they are encouraged to check the items with which they will need assistance and to write further about their problems, as well as to give certain data about their family size and financial status.

Determining financial eligibility is considered only one part of the social evaluation. Usually the family has an initial interview with the medical social worker either in the State office, in one of the regular orthopedic clinics throughout the State, or at home. This evaluation is useful not only in determining eligibility, but also in establishing such a relationship with the family that whatever assistance the family might receive, whether through casework or through financial aid, will bolster the family's feeling of confidence and foster its ability to handle its many problems.

The following examples show the variety of needs revealed:

1. Mrs. T came into one of the orthopedic clinics of the crippled children section in order to see what assistance could be given in arranging for the examination of her 6-month-old baby. She had learned, through the visiting nurse, that the cystic fibrosis program existed. Although she had had the same family doctor for a number of years, he apparently had not known of this program, but had given his consent to the mother's approaching us. Mrs. T said she was worried about the baby having the same symptoms as another child of hers who had died, apparently from cystic fibrosis.

Arrangements were immediately made for the baby to be examined at the closest medical center. In the course of the discussion with the medical social worker, the mother expressed insecurity about telling her oldest child, aged 5, about the baby's visit to the hospital. She said that the older child after having undergone a tonsillectomy, had told her he had looked all over the hospital for the baby sister who had died and couldn't find her. She explained to the social worker that she had not been able to tell the child about the baby's death.

The medical social worker helped this mother think through ways of handling the child's reaction to his sister's death and to the new baby's illness.

Cystic fibrosis was ruled out in this case and no financial assistance was necessary, since the family was able and willing to pay for the diagnostic workup. The social worker feels that the brief contact will enable Mrs. T to deal with her children's questions in a more satisfying way.

2. Mrs. B came to our office for an interview with the medical social consultant and a clinic pediatrician, after learning of the program through the parent of another child. Her child's condition had been diagnosed as cystic fibrosis about 9 years earlier and the treatment had always been through a private physician who lived far from her home. The mother said that there had been times when the family had been in debt for medical care and drugs for over a year at a time.

In this case medication was supplied for the child by the crippled children's section. In later discussions, Mrs. B revealed a number of family problems. She was encouraged by the social worker to use community casework services. Her physician, however, informed the pediatrician of the crippled children's section that she considered herself able to handle all the family's problems.

3. The mother of a child known to have cystic fibrosis wrote to us asking for assistance with medication. Her letter mentioned that she was divorced from the child's father and had remarried. When the medical social consultant visited her home, she found that the mother was pregnant and had been worrying about the possibilities of the expected child having the disease. The family was wealthy, and the mother immediately dropped the idea of accepting a share of any surplus of medication the program might have when she learned that it was a tax supported program with a very limited budget.

The medical social work consultant believes that her visit gave this mother considerable reassurance, both because of the interest she showed in visiting the home and because she talked with the mother briefly about the genetic factors involved in cystic fibrosis and encouraged her to ask her physician more about the chances of the second child having the disease.

In the course of every evaluation, the important role of the parents in the child's care is stressed in an effort to enhance their feeling of worth, and so help them to carry out the physician's recommendations effectively. As in other programs, the medical-social work consultants work cooperatively with hospital social service departments, with schools, and with other agencies as circumstances indicate.

Common Problems

The most obvious problem in most of the families who come to the program, and often the only one they mention, is financial strain. This is easy to understand in view of the fact that the initial work-up at clinic rates costs about $60 per patient; that the drugs needed may run to an expense of more than $1,000 a year; that high protein, and therefore high cost, diets may be recommended; that the family may lose income when a child's illness keeps a parent from working; that trips to specialized clinics, the recurring need for laboratory work, extra attention and care for respiratory infections, which cannot be ignored in cystic fibrotic patients, are also costly.

Added to the financial strain may be the family's feelings about using money needed for other children for one child whom they have been told will not live long. In some cases, the frequently fatal nature of the illness makes the parents feel that it is not only justifiable, but necessary, that they spend almost everything they have for the sick child. For example, one young mother said that she would not consider having another child because it would be unfair to take anything from Danny. The parents were doing without many of the things regarded by most people as necessities, such as a telephone, but were buying expensive toys for Danny.

At the opposite extreme are the parents who in anger and anguish at feeling so helpless in regard to their child seem to say "what is the use of taking care of this child, why should we sacrifice for him?" One father who had had this attitude became very much disturbed when the child died, while his wife, who had been very giving of herself and her material resources, was able to handle her grief in a less destructive way.

The impact of the diagnosis on the parents is always very deep. In addition to the usual reactions to a chronic illness, parents have to cope with the knowledge that the disease shortens life and that it is due to genetic factors. Indeed we have found that even before diagnosis is established, the genetic causation and the frequently fatal nature of the disease have usually been made known to the parents. As in other conditions, the reaction of the parents to the information about the diagnosis depends on themselves and their relationship. The knowledge that both sides of the family are genetically involved, since both parents carry the affecting gene, can become a strengthening tie or a divisive factor. It also faces parents with the need to consider seriously whether there should be more pregnancies.

The recent addition of a geneticist to the health department staff has opened up ways of using genetic knowledge to help parents. While the geneticist does not deal directly with individual parents, he does give counseling to physicians and to the health department staff.

As is common where there are long lasting problems, the presence of cystic fibrosis in a child may have a profound, very disturbing effect on the family life because of negative feelings of various kinds on the part of parents and perhaps too on the part of siblings. A parent unable to accept in herself or himself the negative reactions to his situation, may become immobilized.

For example, one mother we know feels that no one else, not even her husband or her mother, can take care of the sick child successfully. She interprets the physician's statements that it would have helped to have had an earlier diagnosis as a rebuke against which she needs to defend herself. She finds herself unable to make full use of facilities available—to attend the group meeting of the parents' organization, to apply for housing where eligibility would depend on making known the expenses resulting from the child's condition, or to ask for assistance with hospital bills or drugs.

The child with cystic fibrosis may experience much discomfort and fear, especially the fear of death. In addition, he may suffer psychologically from being set apart from other children. He may be either kept from attending school or he may have so many absences that he cannot keep up with classmates.

Because of his difference from other children, the child may be subject to the same kind of questioning and other reactions from people as are children with orthopedic problems. The taking of medicine along with meals, the avoidance of certain party foods, the physical appearance, or the failure to attend school may be commented upon. How the child reacts to such differences will be determined by what they mean to him. One little girl objected to wearing dresses because they showed how skinny she was.

The parent-child relationship may be affected in many ways. Parents may concentrate their feelings so much on the fact that the child's life may be short, that they may have unrealistic expectations of themselves and of the child. They may sacrifice themselves and other children in their attempt to undo the tragedy; they may expect too little of the child, in terms of achievement, happiness, and self-discipline. On the other hand, we have seen adolescent children with cystic fibrosis whose parents have apparently reared them with the same kinds of satisfactions and expectations of self-discipline that a well child would have. We have also seen older children with this disease whose parents arrived rather late to the realization that the child was being handicapped in his personality and that help was needed in learning how to control the disease while encouraging emotional and social growth.

Another effect of the disease on the family is in the relationship between the ill and well children. Various reactions may take place among the sick child's siblings, depending upon many factors, such as the general emotional tone in the family, the condition of the sick child, and the age of the other children. Some siblings become afraid that they, too, will become sick and so avoid the very sick child; others become protective of him. Some reactions are not very different from the reactions that the parents have observed between their well children. One mother stated, "She (the sick child) doesn't like to eat things that are different from the family and the other children don't like her to have something special."

The mother of one cystic fibrotic child who was getting along well physically and in every other way commented that the child always wanted to keep up with the well brothers and therefore would be as active as possible. In one family the grandmother complained that the well child was neglected by the mother and made to submit to every demand of the ill child.

Community Resources Used

Thus, the common problems of children with cystic fibrosis and their families are similar to those of families with children having other long-term, potentially fatal illnesses. In the efforts to promote services for these families in their own communities, the approaches are similar to efforts on behalf of children and families needing various kinds of assistance for other reasons.

The individual child and his family get along better if there is understanding and cooperative planning among agencies. The crippled children section's pediatrician, public health nursing consultant, or medical social work consultant may initiate or participate in conferences about specific children. The agencies most frequently called on are public assistance and family service agencies, medical facilities, schools, and the parent group. In every case conference, the staff attempts to point up generalizations which can be used in other situations.

The needs of children with cystic fibrosis who attend school may not be clear to the school administrators or to the teachers. For example, several instances have come to our attention in which the probability of acquiring respiratory infections increased because of administrative regulations in the school system. In one school the children had to put on their wraps before they ate lunch; they got overheated while eating and then had to go outdoors to play. In another school the children had no opportunity to put on wraps before fire drills. While such regulations may have good reasons behind them, we feel it is important to help the school authorities to understand why they must be flexible enough to allow for individual differences in children.

It is also important for teachers to understand the nature of the disease. We found that one child was not allowed to go to the toilet as frequently as needed, because her teacher had thought her frequent requests were merely an effort to avoid being in the schoolroom. Home teachers of cystic fibrotic children may also need help in understanding the nature of this illness, particularly if they are not used to working with seriously ill children.

In our program we often approach the school indirectly through the parents, whom we encourage to take on the responsibility of letting the school know about their concern for their child, and through the school nurse who lets the administrator and teacher know what the child's condition means. Occasionally a parent may strongly object to letting the school know about the child's condition, but such an objection can be overcome when its basis is understood. We have run into only one instance in which a school would not modify its practices in regard to a sick child after learning of his difficulties.

We have found school social workers helpful not only in working with cystic fibrotic children whose school problems may be intensified by their illness, but also with their brothers and sisters and with their teachers. Siblings need supportive help not only from school personnel, but also from recreational organizations and the significant adults in the child's life. The extent to which public health nurses can be helpful to families of cystic fibrotic children in problems of relationships varies considerably.

Other Resources

The medical social work consultants call on various agencies, according to the needs of individual cases, for funds for items not provided by the program, such as transportation, housekeeping services, or equipment for treatment. We have found family service agencies especially helpful, in localities where they exist, in providing casework treatment of problems of intrafamily relationships.

Occasionally there has been some difficulty in getting family service agencies to accept cases involving cystic fibrosis if the agency sees the illness as the main difficulty. When a family is referred for service to a nonmedical agency, a prior consultation with the agency's social worker may be necessary for the case to become accepted.

There are various ways in which the program's medical social work consultants help workers from nonmedical settings with such a case. They may help these workers to determine the extent to which the family's reaction to the diagnosis is entwined with pre-existing difficulties, or to become less fearful of the child's impending death. They may encourage the agency workers to confer with the physician or hospital social service directly in order to get a better understanding of the situation.

In an institute on children with long-term illness organized for social workers in connection with the State welfare conference, participants asked that considerable time be spent in helping them to learn how to communicate with physicians, especially how to ask for helpful information.

In an effort to acquaint other social workers with the needs of children with cystic fibrosis, a medical social work consultant arranged a meeting and a question and answer period for social workers following a lecture by a specialist in cystic fibrosis.

The program's public health nurse consultants, pediatricians, and medical social work consultants have also spoken at various other meetings to help persons in other organizations and professions in their work with children having cystic fibrosis and their families. We have also made special efforts to encourage better communication between the various professional persons concerned with specific children—such as child welfare worker and physician.

A review of those cases in the program which are under the exclusive care of private physicians indicates that the physicians may not be aware of resources available. This suggests that the public health team may need to take a more active role in helping physicians reach into the community on behalf of their patients.

We are now beginning to work more closely with the State Department of Education's Bureau of Vocational Rehabilitation; for one encouraging aspect of work with cystic fibrotic children is that improved treatment methods are making it possible for these children to survive to young adulthood and to lead more normal lives. In fact, because of these improved treatment methods, it is even possible to forget the admonition that the fully manifest cases of cystic fibrosis are uniformly fatal.

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[1] Andersen, Dorothy H.: Cystic fibrosis and family stress. *Children*, January–February 1960.

> The time is gone when a nation could cite, as the primary source of strength, the number of people under its banner. It is now the quality of people which is important.
>
> *James E. Allen, Jr., New York State Commissioner of Education, to the 1960 White House Conference on Children and Youth.*

HELPING UNEMPLOYED YOUTH—A COMMUNITY APPROACH

SAUL S. LESHNER
Executive Director

GEORGE S. SNYDERMAN
Special Projects Coordinator

Jewish Employment and Vocational Service, Philadelphia

How are young people who drop out of school without having developed any skills or specific interests to find a useful place in society? In the September–October issue of CHILDREN, Dr. James B. Conant described the situation of unemployed youth in our large-city slums as "social dynamite" and suggested that the schools assume greater responsibility for providing guidance services and work experience to young people in and out of school. Here two authors whose job it is to help such young people to become work-oriented present their views of the needs of school dropouts and the kinds of services a community must supply to lead them to an industrious and constructive future.

THE DECADES following World War I were accompanied by an unprecedented growth of our large cities, a growth stimulated and facilitated by advances in transportation, communication, and shift of population from rural to urban centers. While it is evident that marked changes in behavior patterns and personal values occurred in all classes of our population, youth were particularly affected. Removed from a simple to a complex society, many young people developed disorganized patterns of behavior.

We can predict that delinquency and other problems which constitute the "Youth Problem" will increase during the sixties, if for no other reason than that there will be more and more young people between the ages of 16 and 21. During this decade some 26 million young people will enter the labor market, and of this number 7,500,000 will not have completed high school.

Students of behavior agree that the youth who does not complete his schooling is likely to have other difficulties. Whether dropping out of school is the cause or the effect of these difficulties is of little consequence. The point that needs underlining is that school dropouts do contribute more than their share to problems like delinquency, illegitimacy, and even narcotics addiction and alcoholism. And there is also no doubt that these young people have greater difficulty getting and holding jobs and have a higher unemployment rate than high school graduates. This fact is central to both the problem and the solution.

Work in our middle-class culture is the most significant way of achieving success. No goal, youth is taught, is impossible—if one works hard enough one can even become President of the United States. Work, then, is not just the means of earning a living; it is also the way one acquires social status. The image of success in our work-centered society is the person who starts at the bottom and works his way up through the shop and office until he becomes the head of the firm. He does this honestly without taking unfair advantage of his fellows, and while he is achieving success, he is contributing his knowledge, ability, and money to community enterprises.

This ideal, of course, is not attainable by many Americans, no matter how hard they try. The individual who is not fortunate, and who has considerable difficulty finding and holding a job, becomes something of a pariah, an object of contempt. His feelings, already bruised by his circumstances, are further assaulted by the culture heroes of the movies and television who, without working, live a life of ease and revelry. The youth who has not acquired middle-class beliefs in the intrinsic value of work cannot see why he should "sweat for it" when there are so many "easier and faster ways of making a buck."

What we are saying is that the goals of all youth are governed by what is real for them. Deprived youth are aware of their lack of opportunity, and they set goals which they think are rightfully theirs—goals which they can achieve, no matter how. Often they do not care what they will become, or they create problems because they do not try hard enough or because they use ways to attain their goals which are not socially acceptable. Their behavior is a reaction to a negative cultural setting, and only real understanding and a positive desire to help will stimulate these youth to wish to change themselves.

When personal success is life's most important goal, the close interpersonal relations needed for effective modern day living become difficult to attain. The youth who is driven to reach impossible heights is likely to say, "Why should I?" He is in danger of losing his sense of balance in the drive for individual success and to divert any remaining urges to cooperate into unsocial channels.

Background for Delinquency

In every metropolitan area of this country, many delinquents are recruited from the school dropout group. School, court, police, and public employment office records indicate that many school dropouts get into trouble because they have nothing to keep them busy. Tragically, however, schools and community agencies, although recognizing this fact, have neglected to set up well-rounded, closely integrated programs to help these young people become equipped to participate constructively in adult society. Where there are efforts they *are* usually made with a piecemeal approach.

The idea that any single agency or institution can help these young people to "mend their ways" is erroneous for it fails to consider fully either the nature of their problems or the highly individualized basis for each youth's failure to conform. The choice of other views involves one's ability to disengage oneself from customary ways and means of resolving problems. The writers of this article subscribe to the view that these young people are everyone's concern; that all community agencies, voluntary and public, have a role to play and a job to do if our troubled youth are to be helped to find a path out of the jungle which demands social cannibalism to survive. The important task, therefore, is how to mobilize and channelize all the resources of our communities to help these young people develop an image of themselves as "good workers" and then to take their place in society as such.

The task of pasting pictures onto advertising calendars at the work adjustment center of the Jewish Employment and Vocational Service in Philadelphia provides these two young people with an opportunity to learn work disciplines.

Society in America is to a certain degree stratified along socio-economic class lines and most of these delinquent youth come from the lower socio-economic groups. These classes are, in a sense, subcultures with their own traits, standards, and values. Thus, the middle class places great values on close family life, good education, "proper" use of leisure time, the church, and other community institutions. The middle class, accordingly, values morality, respectability, and "striving" to better oneself and family. The class from which most of the school dropouts come requires different responses of its young in terms of learning and goals. It punishes or ridicules what the middle class rewards. Social skills in this class are quite different and aggression is usually approved behavior.[1-3]

The hostility, defiance, resentment, and deep feelings of not being wanted of many disadvantaged young people result in unsocial acts because this is the only way they have of expressing their feelings. Their need to talk with and work with someone who will ask and not blindly demand, must be recognized.

The trauma of school failure can only be ameliorated by the use of interdisciplinary skills, close individualized supervision, and the establishment of clear expectations, and these are not found in the usual school setting. In short, while the schools have a responsibility to adjust their programs to keep potential dropouts in school insofar as possible, training young people to develop attitudes and motivation for work can be accomplished more effectively in a work-oriented environment by persons with particular skills and orientation.

The Philadelphia Program

To illustrate this point it will be useful to review quickly what can be done to help young people find their way into the world of work. We cite what is going on in Philadelphia because there a progressive city administration has been attempting to resolve many of the problems, because the school counseling program is competently administered, because there is an effective employment service which has proved that many school dropouts can be placed in employment, and, lastly, because there is a network of voluntary agencies, which if properly mobilized and fully used could add the necessary impetus which thus far has been absent.

On one occasion all agencies of the community supported the efforts of the local office of the State Employment Service to help the "hard-core youth," that is, the out-of-school, unemployed, and untrained young people, aged 16 and 17, living in a neighborhood ranking highest in the city in delinquency, crime, illiteracy, poverty, desertion of children, and illegitimacy. Seven hundred and eighty-two boys and girls were dealt with by just two counselors, with rather striking results because for the first time someone actively involved these youth in their own rehabilitation. This experience shows that young people like these can be helped, that they desperately want to be helped, and that some suffer anguish because of their failure to adjust. Altogether 242 of these youth (31 percent of the total) were placed in competitive employment through the provision of considerable counseling (2,511 interviews) and a tremendous number of phone calls and visits to employers (5,839). The small number of youth (3) who failed to accept an employer's offer of a job indicates how much help the counselors gave and how much these youth learned. More important, none of these youth created a serious disturbance at his place of employment.

The Philadelphia counselors found that these young people need constant stimulation. If allowed to drift, they revert to their old habits; but if they learn to seek stimulation, they adopt the approved standards of our society. They are more realistic about their status and role with respect to work than we assume. Generally, they aspire to and will perform best in low-paying entry jobs which are not sought by mature, experienced persons, so that any fear that the placement of youth will displace married men is ill-founded.

Another noteworthy fact emerging from this project is that, for these youth, vocational goals are meaningless unless placement in a job follows quickly. Unless the boys and girls see the results in terms of at least a referral to a paying job, they become impossible to reach.

The School's Role

An additional conclusion may be drawn from the employment service's experience. Even in the subculture in which so many of these unemployed youth live, some kind of work is essential. Since a person's adjustment to work depends on his life's experience, these youth are handicapped because their previous experiences had been thwarting and negative. The community must find some way to help these youth become good workers. Young people who are potential school dropouts need to be identified by the schools at age 14 or 15 and referred to a community agency which is equipped to give specific help and professional attention to each youngster while he is still in school. The help these youngsters need cannot be given in classrooms or schools because they have already failed to adjust to the institutional setting which is the school. This failure accounts for much of their anxiety and hostility. The school, however, has an obligation to re-examine its program to find ways of making these young people's school experience at an earlier age an interesting rather than a frustrating experience.

The schools, of course, should have a responsibility for these youngsters until they are 18, but there is some question whether schools typically are able to cope with and help them. It would seem, therefore, that the schools' responsibility can be wisely exercised by referring these youth to a community agency which is non-institutional and which is adult in character. Work in a realistic setting where authority is permissive, and where the youth have an opportunity to develop skills and habits in terms of their own achievement, will help them to adjust better. In this type of environment, their basic needs for self-determination and independence are met, and they gradually develop the self-image of a "good worker."

Formal institutional training usually fails with these youth because the youngsters themselves cannot be categorized. More important is the fact that institutional training symbolizes a continuance of the dependency which the school setting incurred. This is, perhaps, the most important reason why many of these youth fail to enroll in trade or business schools when they leave school.

Some Suggestions

Several general solutions are often suggested for the youngster who cannot accommodate themselves to school. They may be summarized as follows:

1. *Removal of the youth from school to prepare him for work* in a real work setting as a trainee or apprentice.

In a nonschool environment the youth has a chance to develop skills, learn to get along with other workers, develop personal responsibility for his productivity, build tolerance for work pressures, develop such work habits as punctuality and observance of rules. Since these factors constitute the American image of a good worker, this solution would help some of these drifting young people.

This way, however, is not suitable for most of these youth because they are not ready to work—they first need to be helped to see that they can work. Moreover, there are few on-the-job training opportunities for youth generally, and disadvantaged youth are simply not able to compete for them. The proposed Federal "on-the-job training" program would increase the number of such opportunities.

2. *Additional vocational training in a school setting* either directly or cooperatively with industry.

This is an extension of the school's authority against which these youth have already rebelled. As a matter of fact, it has been observed that traditional vocational training programs usually exclude the "low-level" youngsters because they do not have the "aptitudes" or "interests."

3. *A public works program.*

This, in the opinion of most persons concerned with unemployed youth, is a necessity. Such a program requires considerable planning, supervision, and money. As of this writing, the City of Philadelphia has been able to provide work for only 200 youth. The results achieved in cutting down delinquency and truancy among those so employed have been gratifying.

4. *Work-adjustment training.*

This involves removing the youth from their pattern of failure by introducing them to adult work, thus breaking the pattern of resistance and immaturity and nurturing maturation of personality. For many young people this type of program may lead ultimately to a return to school during the evening because the school will have a meaningful supplementary value. Many others may also be helped through this means to become "good workers" and contribute to the welfare of their families and communities.

Work-adjustment programs are relatively new and are sometimes known as "job adjustment" training. Generally, work-adjustment centers represent for disadvantaged youth a greater opportunity to learn and see how they can compete. The centers enable them to test themselves in a variety of work settings, achieving on many real work tasks, until they build tolerance for pressure and ability to integrate and organize their energies.

Work Adjustment Training

The Philadelphia Jewish Employment and Vocational Service, a voluntary community agency, has operated a work-adjustment program since 1957. Conducted in an industrial workshop with a true work environment, it is used to assess work tolerance and capacities. With the aim of rehabilitating persons of all ages who have emotional and mental handicaps, the program is supported by the Office of Vocational Rehabilitation as a research and demonstration project.

In the program a good work personality is developed by controlling and manipulating psychosocial factors and working conditions. Dealing with youngsters with all kinds of behavior problems has shown that these youth create an emotional shell over their feelings because they cannot tolerate their own anxieties. When confronted with rigid authority they break through this shell with highly explosive reactions. The programs of the Work Adjustment Center of JEVS provides a benign authority and enables the trainees to relate with and develop a trust in authority. It permits them to express healthy natural dependency feelings. The freedom of being without conflict in a wholesome, modulated work environment helps them to begin to channelize their energies toward constructive ends.

Placed in this environment, the individual youth receives encouragement, praise, and direction from an industrial foreman who is firm, consistent, and understanding. The youth begins to work through his problems of learning to be a "good worker." He takes an interest in his productivity. His interest is reinforced because he receives pay for the quantity and quality of work he produces. He learns that in competitive industry one must be able to produce and get along with supervisors and peers. He learns this positively through praise, monetary rewards, and negatively through loss of pay and privileges. This is the pattern of American industry. Unless the individual learns these lessons well, he is not ready to plan for vocational training, work, or return to school.

An Individualized Process

Work-adjustment training is a highly individualized process since all youth do not react alike. Included in the process are supplementary techniques such as individual and group counseling, and the auxiliary services rendered by other agencies—family casework, psychiatric treatment, and job development and placement. Parents or other responsible family members are helped to understand, cooperate, and participate by interviews with the psychologists and counselors. They can be involved without feeling threatened, for there is nothing punitive or legalistic about the program. Contrast an invitation to see Johnny working, being accepted, and trying to succeed, with an order to come to school because he is failing, is truant, and generally troublesome.

Work includes much more than skills. Persons fail to secure or hold jobs because of factors other than occupational skills in the ordinary sense. The problem of placing the youth, therefore, requires that the counselor help the youth demonstrate to a prospective employer that he is the kind of person who can perform the required tasks and can become a member of the production "team." In the program the young person is prepared for this by being exposed to a variety of work tasks.

The rationale of the program is to make Johnny flexible first, then get him started in employment. If Johnny is really prepared by his shop experiences, he will have the psychological integration to stimulate himself first to be a successful worker and then to seek advancement. Having successfully completed a work-adjustment program, finding a job becomes easier. Johnny will use our placement facilities and those of the State Employment Service, the State Bureau of Vocational Rehabilitation, or any other agency or person, because he has developed a tolerance for work and a way to accommodate to his peers and supervisors. And most important, he has subdued or learned to live with his anxieties.

Vocational counseling in this program capitalizes on all the gains and growth which the individual has made in the program. The counselor starts at the point the youth has reached as a result of his work-adjustment training. The counselor recognizes that Johnny is a unique individual who must learn to make his way in a complex world which demands continuous interaction with others. Determining what Johnny needs to do to adjust, the counselor supports his efforts to learn more about himself as a worker. He teaches him how to define goals and find good ways of achieving them.

The responsibilities of the counselor do not end when Johnny is adjusted to a job of his own choice. Even after the youth succeeds, he often needs to be helped to take additional steps toward reaching a maximal level of employability. Will he need additional training, and, if so, when and where? Questions such as these are relatively easy to handle. In areas dealing with interpersonal relations, answers are usually not as obvious. But, only when the youth can find them will he be rehabilitated.

The reader will gather from this article that there is considerable work for every agency. A complete program for all youth will include adequate schooling and educational and vocational counseling plus work-adjustment programs as indicated.

A total program is now possible. We need, however, to find ways of defining lines of authority and responsibility. Agencies need also to learn to respect and use each other if they wish to help our youth.

A comprehensive, integrated program is not cheap in terms of money or agency prerogative. It is, however, an inexpensive way to bring better and happier lives for youth; and it will result in huge savings on maintaining institutions, courts, police, and other agencies concerned with social and individual breakdown. We no longer can afford the luxury of postponing cooperative efforts on behalf of disadvantaged youth.

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[1] Witmer, Helen L.; Kotinsky, Ruth (editors): New perspectives for research on juvenile delinquency. U.S. Department of Health, Education, and Welfare. Children's Bureau Publication No. 356. 1956.

[2] Teeters, Negley K.; Reinemann, John O.: The challenge of delinquency; causation, treatment, and prevention of juvenile delinquency. Prentice-Hall, New York, 1950.

[3] Polsky, Howard W.: Changing delinquent subcultures; a social-psychological approach. *Social Work*, October 1959.

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With the goal of improving the quality of foster care a child placing agency experiments in . . .

THE USE OF GROUP METHODS WITH FOSTER PARENTS

CAROLYN THOMAS

Supervisor, Southwest District, Family and Children's Service of Greater St. Louis

IN THE PAST 30 YEARS there has been considerable change in the reasons children are placed in foster homes. Foster home programs, like children's institutions, were originally developed to care for orphans—children who had lost one or both parents through death. However, advances in medical science have sharply reduced the number of orphans in the United States, while social security programs have enabled mothers and children to stay together even if the breadwinner is no longer with the family.

This implies then changes in the kinds of children who are placed in foster homes and in the task of foster parents. As a result foster families must give much more than food, shelter, and love to children. They must become part of a child-care team of experts, helping children who are emotionally upset and who face more than the usual problems in reaching adulthood.

Today in the United States there are 268,000 children in foster care boarding homes and institutions. The recent Child Welfare League of America study of children in foster care shows that ". . . the single most important cause of foster placement of children is marital breakdown."[1] The adverse affects of parental conflict on children shows up in the children's difficult behavior.

Family and Children's Service of Greater St. Louis, a voluntary agency offering family casework and child welfare services, conducted an agency self-study in 1959. This study included an analysis of children in foster family care. Two-thirds of these children were from broken homes. They showed severe problems requiring the most skilled casework or psychiatric treatment. The behavior of these children was described as immature, anxious, withdrawn, schizoid, or acting-out. The study raised the question of how we could increase the ability of foster parents to meet the needs of such disturbed children.

Traditionally foster parents have considered themselves good people with an abundance of love for children. They have expressed this love through opening their homes to children. However, most foster parents have not expected or been prepared to deal with children showing such a magnitude of problems, nor have they anticipated the constant shadow of the child's own parents in his life or the active role of the agency in caring for a foster child. The study indicated the need for additional ways of helping foster parents come to grips with these problems and provide the best possible care to children.

This need was highlighted further by other findings in both the agency self-study and the Child Welfare League study. The agency's study showed that one-third of the children in foster care were not having their needs fully met in the foster home—both because of the severity of the child's problems and the limitations of the foster parents. It also showed that 20 percent of the children in care had been moved from one foster home to another. The Child Welfare League's study showed that emotional disturbances were greatly increased among children who were placed in a succession of foster homes. These findings raise several questions: How can replacements be prevented? How can turnover of foster parents be reduced and a more experienced, skilled group of foster parents be developed?

We have found that foster parents first begin to grasp the concept of working with the agency to help children when their home is being studied as a possible foster home. They also begin to anticipate the impact on their family of including a child not their own—a child with more difficulties than their own children ever had. Then, the caseworker responsible for the child to be placed establishes a working relationship with them to develop their skill in helping this particular child. The foster parents and the caseworker also focus on the adjustments the foster family will have to make to enable the members of the foster family to help the child become part of their family and their community while he lives with them.

A Supplementary Method

After the agency's study was completed it was decided that an additional method was necessary to help foster parents to learn more about helping children and to work with the agency for this purpose. Therefore in 1959, the agency initiated a series of group meetings with foster parents.

The group method was chosen as a way to achieve certain goals more effectively than is possible on an individual basis. It in no way takes the place of the work of caseworker and foster parents in relation to a particular child. Instead, it supplements this individual relationship, and makes it more effective by increasing the foster parents' understanding of their own and the caseworkers' responsibility.

A major goal of the group discussions was to increase the foster parents' identification with the agency. We felt that, if foster parents were identified with the agency, the agency and the foster parents could develop mutual goals for helping children and then clarify the respective roles of foster parents and agency in meeting the needs of foster children. These achievements would then make it possible to anticipate a much more effective working together on individual cases. We also felt that through the group discussions, foster parents' understanding of children's behavior and the meaning of placement of children might be increased.

We felt that through using the group method, foster parents and agency staff alike would be able to learn from each other and to find support in their struggle with specific problems. The foster parents would be enabled to consider their own functioning as part of a larger whole and to express anxiety and negative reactions more comfortably within the group than otherwise. The group discussions might also make it possible for the foster parents to achieve a better understanding of changes in their foster child's behavior and to make appropriate changes in their methods of handling him, as well as for the agency to achieve a better understanding of foster parents' problems, which might lead to changes in agency policies and procedures.

If the above goals were achieved we felt sure there would be a smaller turnover of foster parents, development of a group of more experienced and more skilled foster parents, more effective service to children, and fewer replacements.

It is too early to tell how near we have come to achieving these goals. However, there were no replacements of children during the first year of the new program. Moreover, a questionnaire answered by foster parents in the spring showed a majority liked the group meetings and considered them helpful.

Altogether six 2-hour monthly meetings were held with each of four foster parent groups during the 1959–60 year. The groups were made up of (1) people boarding children beyond infancy and, (2) people boarding infants, most of whom would be going into adoptive homes at an early age. The

A caseworker from the Family and Children's Service of Greater St. Louis leads a group of foster parents in a discussion of the problems and possibilities of foster care.

second group was divided into three sections based on geographic location of the foster home. The groups were interracial. Meetings were held at night so both foster parents could attend.

Notices of the meetings were sent to all foster parents who were boarding children at the time, but participation in the groups was voluntary. Altogether foster parents from 53 different families attended at least one meeting. The discussion leader for all the meetings was a staff member of the agency's foster home department primarily engaged in home finding. The caseworkers responsible for the children in foster homes were not invited to the meetings lest their presence inhibit discussion about problems or cause too much focus on the specific problems of a particular child. While the number of people at the meetings varied from 8 to 20, a group of 10 to 12 seemed to be the most effective size for discussion.

Changes Indicated

The experience with this plan during the first year seemed to call for some changes and additions. We wondered whether other caseworkers should participate in the meetings. However, when a meeting was held with two staff members present we found this tended to divide the group and decrease the foster parents' identification with the agency. Also, it might have prevented the foster parents from criticizing the agency and its caseworkers. When such criticism did arise in the meetings, it resulted in increased mutual understanding between foster parents and agency. Therefore, we continued the plan of having one person serve as discussion leader for all meetings.

During the 2 years of the experiment the foster parents were not actively involved in program planning for the meetings, though their ideas for future meetings were requested at the close of each meeting. Further meetings of this type, we believe, should be planned by a steering committee, composed of foster parents and staff.

We found too that the changing attendance at each meeting tended to slow down the process of the group and to necessitate considerable repetition for some members who attended every meeting. Therefore, it is recommended that, in such experiments, minutes of meetings be taken and mailed to all members. Another recommendation growing out of our experience is to establish a small group of foster parents who give care to older children to meet with the caseworker responsible for these children, requiring their attendance as part of the responsibility foster parents assume in caring for such children. This group is functioning on a more intensive basis than the others.

The first meeting of each group has been used to interpret total agency program and services and to clarify the foster parents' role in this larger framework. Succeeding meetings focused on development of children and the meaning of and reaction to placement—both for foster children and foster parents. Though these meetings have an educational base, the group discussion method of drawing on the experience and knowledge of the participants is used rather than a lecture approach.

Some meetings have focused on discussions concerning agency procedures and problems unique to boarding children. In these the foster parents have tended to concentrate on problems of dealing with visiting parents and on trying to determine the agency's role and their own role in every area of foster care.

Identification with the agency and a developing awareness of the foster parents' part in the team approach to child care has come about through many different discussions during the meetings. For example, in one group the initial discussion about the total agency program revealed that people in the community often turn to foster parents for help with specific problems because they recognize foster parents as being part of an agency that helps people. After this meeting there was an increase of referrals from foster parents to the agency of people needing counseling services. The foster parents identification with the agency enabled some people to accept referrals who might otherwise have been unable to do so.

Handling Hostility

In one meeting, some of the foster parents expressed considerable hostility toward the agency. This showed up at first in the form of complaints about foster parents having to wait too long between placements so that they were frequently without children. The leader's response to this question indicated her failure to understand that these complaints reflected the foster parents' concern as to whether or not they were needed or were worthwhile. Her enthusiastic philosophical comments about early adoptive placement being the agency's goal—implying this was good whether or not foster parents liked it—represented defensive intellectualization rather than an encouragement of the expression of angry feelings so they could be resolved. If hostile feelings toward the agency exist among foster parents, it is necessary for them to be expressed before the foster parents can take on a more positive identification with the agency.

On the other hand, another meeting showed the way in which criticism could be turned back to the group and be used to develop active, positive participation and increased group and agency feeling. A foster mother asked if the agency were going to continue to use the baby books, and criticism of these books ensued on the grounds that they were not appropriate for pre-adoptive infants and needed to be designed specifically to serve as a record of the child's development in the foster home, which could be passed on to the adoptive parents for continued use. As a result, a committee of foster parents who volunteered for the purpose, meeting with the group leader, developed a new baby book and presented it at the next meeting.

The committee members were so enthusiastic about their project that they planned refreshments for this meeting. Since refreshments in the past had come from the group leader, this act seemed symbolic of two things: (1) celebration of a completed task: (2) a reflection of the foster parents' growing freedom in participation and their wish to make the group theirs. The foster parents continued to bring refreshments to succeeding meetings.

Identification

I have already stressed the importance of foster parents being identified with the agency. The following excerpt from minutes of a group meeting shows how one foster mother's failure to be identified with the agency had interfered with sound planning for a child:

> Mrs. L tentatively raised the question that is bothering her most. She asked, "What are you supposed to do if you've boarded a child, the child returns home, and then the parents come back to you asking you to take the child?" (Mrs. L had taken the child in and failed to notify the agency.) The leader asked the group to react to this. Mrs. A said, "Well, you wouldn't take the child without notifying the agency." Mrs. C nodded agreement and stressed this too. Mrs. D said, "Well, of course you'd notify the agency," and there was general agreement and shaking of heads.
>
> Mrs. L continued: "But what if you can't get hold of anybody at the agency?" Several in the group spontaneously responded with comments that you can always get in touch with someone. Mr. J suggested that the agency prepare foster parents for something like this if they anticipate such a problem occurring.

Mrs. L was clearly acting on the basis of her own feelings without awareness of her responsibility as an agency foster parent. Previously, in individual contact with an agency staff member, Mrs. L had defended her action and failed to be convinced that she might have handled the problem differently. Her efforts to project or explain her behavior were not successful in the group. The other foster parents did not support her defense, but rather helped her to see that foster parents as part of the agency can comfortably turn to the agency for help with problems.

The foster parents' conflicting feelings about being foster parents came out quite strongly in several meetings. The group discussions, as well as the fact of meeting and knowing other foster parents, seemed to bring an increased sense of status in being foster parents. We are counting on this increased pride in the role they have taken on to help with the interpretation of foster care in the community and in the recruitment of boarding homes.

The foster parents' revealed that they usually meet with two different attitudes in the community in regard to the fact that they board children. One is critical: Why take care of someone else's child and let the real parents get away with not assuming responsibility? The other attitude is sentimental: How wonderful foster parents are to help some poor, helpless child! In their group discussions many of the foster parents came to grips with their own motivations and said that they boarded children because they enjoyed it and were getting something out of it for themselves as well as helping a child. They seemed to gain a great deal of support in being able to bring feelings into the open in a group having similar experiences.

Specific Problems

The group discussion method of dealing with specific problems involving clarification of both foster parent and agency roles is illustrated by an excerpt from the minutes of one of the meetings:

> In discussing visiting parents, Mrs. J said: "I think all visits with child and parents should take place in the agency office. Why isn't it done this way?" Mr. and Mrs. M both spoke up saying they had had problems with visiting parents—one mother had stayed until 1 a.m. and then had to be driven home because the buses were no longer running. Mrs. C chimed in about the child she's boarding—the mother is supposed to come at 11 a.m., but doesn't show up until 3 p.m., and, since this mother is "mentally upset," Mrs. C is afraid to say anything to upset her more. Mrs. J asserted that she is capable of taking care of babies but not of problem parents—"that is the agency's job."
>
> The leader said she wondered what experiences other foster parents had had. Mrs. A said she and her husband never had

any problems with visiting parents; they are just "very definite" with them. She added, "Don't let anybody take you for a fool." Mr. A supported his wife, saying, "you have to be firm and definite." Mrs. M asked how to do this, since when you're nice to the mother she takes advantage of you. Mrs. K stated she had been very firm with parents and told them to leave when the visiting time was up. Mrs. J and Mrs. R said that perhaps Mrs. A and Mrs. K could do this, but they could not tell parents they had to leave the house.

Mrs. C and Mr. and Mrs. M expressed relief that other people had this problem. They said they had wondered if they were doing wrong or not handling the problem correctly, and were encouraged to know that it must not be entirely their fault.

The leader raised the question of whether or not the foster parents had contacted the agency when problems had come up about visiting. They said they had hesitated to get in touch with the agency because they thought they should be able to handle the problems themselves. Mrs. A pointed out that agency and foster parents work together and that the agency could be of help. The leader pointed out that the agency expects problems, and that while neither the agency nor the foster parents can handle every situation perfectly, both could do a better job through working together with confidence in each other.

At the end of the discussion, Mrs. C and Mr. and Mrs. R said that they have had bad experiences with visiting parents, but that they think they will be able to do a better job in this area in the future.

This illustration shows the lack of confidence several foster parents have in their own ability and their hesitation in revealing this to the agency. The people involved gained considerable support through the group discussion and were able to feel more confidence in themselves when they discovered that others had the same problem they had.

Some of the group meetings were devoted to discussions of children's behavior. For example, the group leader opened a meeting with some brief remarks about how children's development follows certain stages or patterns, emphasizing the unevenness of emotional development and the tendency and necessity for regression when the child is under stress. She asked the group if they had illustrations of this. One foster mother said that her 3-year-old foster child wanted to be held and wrapped in a blanket like a baby. She and her husband had met the child's request but were uneasy about it. Most of the members of the group then gave examples of regression and how they had handled it, and some commented after the discussion that they now had more understanding or comfort in dealing with this phenomenon.

This discussion shows how members of a group can produce meaningful and helpful material out of their own experience, and so help other foster parents increase their knowledge about child development.

About a year ago our agency made a survey of 18 family and children's agencies in the country, requesting information about the use of group meetings with foster parents. Nine agencies replied that they did not have group meetings with foster parents on a regular basis. Some had an annual meeting; some had tried group discussions in the past; and others wanted to develop a program but did not have staff time to do so. Five agencies described programs of foster parents' meetings or clubs, and reported positively on the values of such meetings.

For example, one agency wrote: "We cannot emphasize too much that caseworkers and foster parents began, and are continuing, to integrate in their thinking and in their work the concept that each is part of one agency, that each has a specific job to do which the other must understand and respect, and that one cannot go ahead if the other is left behind alone."

Our own experience as described here has led us to believe that group meetings with foster parents, using group discussion techniques, are of value in developing better working relationships between foster parents and agencies in helping children, and have increased the foster parents' understanding of their own and the agency's roles; their confidence in carrying out their functions, and their knowledge about children's behavior and needs.

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[1] Maas, Henry S.; Engler, Richard E.: Children in need of parents. Columbia University Press, New York, 1959.

Could I climb to the highest place in Athens, I would lift up my voice and shout: "Fellow citizens, why do ye turn and scrape every stone to gather wealth and take so little care of your children to whom one day you must relinquish it all?"—*Socrates, 400 B.C.*

A study reveals many personal and family factors having a bearing on . . .

MATERNAL EMPLOYMENT AND CHILD REARING

MARIAN RADKE YARROW

Chief, Section on Social Development and Family Studies,
National Institute of Mental Health, Public Health Service

"WHAT ARE the effects of maternal employment on children?"

Unfortunately, when this question is posed in *this* way no really scientific answer can be given, for the question is posed much too simply. It is only slightly more meaningful than the question: What are the effects on children of the *non*-employment of mothers?

An evaluation of existing research [1] permits only the interpretation that maternal employment has little or no effect on child development—or that employment can be related to almost any kind of outcome. Those few differences reported in the literature are not consistent with one another and hence only add to the impression that mothers' working can be dismissed as one of many factors affecting the directions in which children develop, probably not a very important one. But I think these conclusions are in error. Mothers' working or not working, translated into relevant conditions of the psychological environment and of the parental role, must surely make a difference if existing developmental theory is valid.

Maternal employment is a very special kind of variable in the study of child development. It is *not* like social class or developmental stage or sex, each of which is composed of a relatively predictable set of interdependent attributes. Psychologically speaking, maternal employment is composed of many different factors not at all similar from case to case. These differing factors need to be disentangled in investigating influences of a mother's work role on the child.

Proceeding toward such disentanglement—maternal employment is, first, a psychological variable in respect to its *meaning* to the mother. Thus it may variously be a contributor to self-esteem, a focus of critical inner conflict, a personal competitive weapon, a means to economic survival or the attainment of social goals, an escape, or an involvement received supportively or hostilely by the significant people in her life.

All of these meanings and many more are represented in mothers' decisions to work or not. Research, therefore, might well be directed to finding out what the consequences are for the mother's relationships with her children for her own personal frustrations and failures, her feelings of fulfillment and attainment, or her resentful assumption of a parental dominance role abrogated by her husband as these are linked with employment or nonemployment. But it would seem of doubtful value to combine these differences into one group of employed mothers, and to look among them for common family or child-rearing characteristics.

Levels of Variables

Let us call the *personal meaning* of maternal employment a first level variable, for purposes of later reference. There are also second and third level variables to be considered in reformulating the question of the significance of maternal employment in the child's development. At the second level, mother's work may involve any of a number of *structural* changes in the rearing environment. In the traditional family in our society, the child's rearing is the responsibility of a pair of parents, with the mother assuming primary care and socializing functions, and the father, less present, assuming specialized or more diluted responsibilities; and with the first influential nonparental figure coming into the child's life at the time of school entrance. Maternal employment may alter this structure of rearing, but not uniformly.

The mother's working may bring several authority figures and affectional figures into the child's life at an early age. Working may separate child and mother. It may bring the father into prominence as a rearing agent. It may magnify the significance of the child's friends of his own age. In these *structural* variations we have the variables most relevant to the child's development but they tend to get lost in research under the label of maternal employment.

The third level variable: Working may result in changed child-rearing practices of the kind investigated most frequently—such as the techniques of control, the degree of supervision, the nurturance of dependence and so on. But it does not seem sound to begin to look for variations in these patterns associated with work status unless the intervening conditions (levels 1 and 2) are taken into account. Even if specific aspects of rearing patterns were to show differences between working and nonworking mothers, we would still find ourselves in extremely difficult and speculative positions in attempting to "explain" the differences.

An illustration comes from an interesting study by Hoffman [2] and reviewed by Stolz. They discuss a finding of differences between working and nonworking mothers in the amount of affection shown their children. Working mothers are reported as showing the greater affection. Hoffman offers the hypothesis that working mothers who enjoy their work are motivated out of guilt feelings to show greater affection toward their children. Stolz suggests the alternative that both love of work and love of child derive from common positive underlying factors in the mother's personality. What then can we conclude about consequences or correlates of working as they are likely to affect the child? If we make the big step from work status to mother's specific rearing behaviors, we will inevitably end up with data ambiguous in meaning.

Maternal employment should open our eyes to the importance of studying certain maternal factors to which child development research has not given much attention. These are: variables in the life situation of the mother as a person, her identities as a woman, and the interaction of these factors with her mother role. This opens a wide door, but here I will touch only on factors which relate to the meaning of the work role for the woman, and the meaning of the nonwork role.

Meaning of the Work Role

In designing a recent study of maternal employment carried out at the National Institute of Mental Health, Department of Health, Education, and Welfare, we selected five areas about which women have attitudes, goals, satisfactions: (1) What ideology does the mother have regarding *masculine-feminine* roles? (2) In her conception of a "full" life for herself, *what roles does she see* for herself? (3) What are her strivings and attainments with respect to *personal achievement?* (4) What goals are fulfilled by combining work with wife and mother roles? (5) Out of the complex of status factors, responsibilities, personal relationships that constitute mothering, what is the chief meaning of mothering to her?

Our sample was 100 mothers—50 working, 50 not working—from middle and upper middle social classes, white, suburban or urban. The families of all were intact; all had children of elementary school age. The families of the working and nonworking mothers were comparable in size and in the age and sex distribution of the children.

The variables we studied were: (a) qualities of mothering that we regarded on continua of *deficiencies to adequacies*, and (b) *differences* in rearing not necessarily reflecting a "good" or "bad" dimension.

In group (a) we specified a number of essentials for "good" mothering. For example: At a cognitive level, a good mother has some formulated principles regarding child rearing, some awareness of direction. These principles include recognition of the importance of supporting the individual potentialities and growing independence of the child. The practices of the "good" mother are not glaringly inconsistent with her principles. She is able to provide clear limits for the child, and to provide controls in the child's environment which are accepted without pervading conflict between child and parent. The "good" mother's relationship with her child reflects sensitivity to his needs, gives emotional satisfaction to the mother (to the child, obviously, as well, but this we could not measure). She is confident about her child rearing, though she is not necessarily without problems. Each of these variables was considered individually and a quasi-scale of adequacy of mothering (the sum of ratings) was also used.

The variables in rearing not necessarily reflecting adequacy of mothering included different techniques of discipline, degree of strictness, mother versus father's role in discipline and affection, permissiveness of aggression, independency training, intellectual achievement motivations of mothers for their children, sex role typing, and parental participation with the children.

First, we looked for an answer to the research question everyone asks: Do working and nonworking mothers differ? Our data provide an overwhelmingly negative answer, both in "adequacy" dimensions and in differences in rearing.

Here are several examples: Clearly formulated principles for rearing children were expressed by 54 percent and 46 percent of the working and nonworking mothers, respectively. When the area of control was evaluated in terms of the degree to which mother or child was in control, in 4 percent of the cases in each group the child, not the mother, was in control; in another 18 percent there was persistent jockeying for control by mother and child.

The only suggestion of a difference between the two groups appears in the greater frequency of occurrence of marked overt rebellion and outbursts of protest by the children of nonworking mothers (28 percent as compared with 10 percent in the children of working mothers). Nonworking mothers are rated slightly higher in reflecting sensitivity to the child's needs (30 percent as compared with 12 percent are rated high in sensitivity.) Fewer of the nonworking mothers (24 percent) express lack of confidence within the child-rearing role than do the working mothers (42 percent).

Two dimensions in which differences between working and nonworking mothers were anticipated but in which no differences were found are sex typing and time spent with children. The two groups show no difference in mothers' philosophy or practices regarding social sex roles in the rearing of boys and girls, and (using assignment of household responsibilities as one indication of sex roles) are equally likely not to adhere to traditional sex roles. On the basis of the kinds of activities mothers reported sharing with their children, evaluations were made of how much the mother participated in activities primarily of the child's interest. Thirty percent of the working mothers and 16 percent of the nonworking mothers were rated high in participation with the child in activities planned around the child's interests. While this is not statistically significant, it is evidence against the expected direction of difference.

Role Preference

We then refined our grouping of mothers to take into account the meaning of work and nonwork. We discarded one variable, masculine-feminine role ideology, for in this the mothers were much alike. Except for a very small extremely "feminine" group, differences among the mothers were so minor that we could not use this variable for subgrouping.

Our next variable, the woman's preference regarding working or not working, provided four distinct groups: working mothers who preferred not to work, working mothers for whom work was the desired state, nonworking mothers who preferred not to work, and nonworking mothers who wanted to work. Briefly our findings are that when work and nonwork are analyzed in terms of the goal areas they represent for the mothers, there are associated differences in child rearing.

Replies to two questions determined whether the mothers were classified as preferring or not preferring to work: (1) if given the choice, would the mother want to work, and (2) how would she rank a number of alternatives involving job, marriage, and children? Seventy-six percent of the working mothers and 82 percent of the nonworking mothers indicated preference for their present situations. The four resulting subgroups, based on actual and desired work status, were compared in their child-rearing characteristics.

We found that when maternal motivations regarding work are considered, significant group differences in child rearing appear. The questions about these differences can be asked in two ways: (1) Do working and nonworking mothers who are similarly satisfied (or dissatisfied) with present status differ in child rearing? (2) How do working mothers who prefer to work and those who do not prefer to work compare, and, similarly, how do nonworking mothers who prefer to work and those who do not prefer to work compare in child rearing?

Dissatisfaction with present role appears to contribute significantly to mothering functions, according to our findings. The variable of role satisfaction is markedly differentiating, especially among mothers not employed. If mothers are in their *preferred* work or nonwork *role*, working or not working makes little difference in their child rearing. In only two of the characteristics are there suggestive differences: Satisfied nonworking mothers tend to have somewhat higher ratings in sensitivity to their children's needs; also they have slightly higher scores on adequacy of mothering than satisfied working mothers.

However, when *dissatisfied* working and nonworking mothers are compared, differences appear in areas of control, emotional satisfaction, confidence in child rearing, and adequacy of mothering. Dissatisfied nonworking mothers report more overt rebellion in the children, slightly greater lack of clarity in limit setting, more frequent presence of a continuing "battle" for control between mother and child, and slightly less emotional satisfaction and confidence in child rearing. The sum of ratings shows significantly lower scores on adequacy of mothering by dissatisfied nonworking mothers than by dissatisfied working mothers.

From *within* the group of *working* mothers, role preference does not make a difference on scores of adequacy of mothering, according to our data. However, dissatisfied working mothers tend more than satisfied working mothers to indicate unclear limit setting for the child and to report themselves as less strict than the father in the control and discipline of the children. They also tend more than the satisfied working mothers to describe themselves as fostering independence, assigning more responsibilities to the child, but finding the child less willing to make his own decisions.

WHO ARE THE WORKING MOTHERS?

According to Bureau of the Census data, the proportion of mothers in the labor force increased by almost 50 percent from 1948 to 1958. A recent Children's Bureau review of Bureau of the Census figures indicates that while the rate of increase has been greatest among the middle and upper income groups—the groups to which the mothers described in this article belonged—economic necessity is still the major factor in leading mothers to the labor market. According to the pamphlet, "whatever the age of the child, mothers living with their husbands are about 'half' as likely to work as 'other' mothers." In 1957 among mothers with children under 6 years and living with their husbands, only 7 percent of those whose husbands made over $10,000 were in the labor force as against 25 percent of those whose husbands made from $1,000 to $3,000 a year. ("Children of Working Mothers," by Elizabeth Herzog, Children's Bureau Publication No. 382, 1960. Price 20 cents from the Superintendent of Documents, Government Printing Office, Washington 25, D.C.)

Within the group of *nonworking* mothers, role preference is most clearly related to mothering differences. Dissatisfied as compared with satisfied nonworking mothers show less clarity in limit setting, less consistency between stated principles and practice, more continuing "battles" for control between mother and child, less emotional satisfaction and confidence in child rearing, and less adequacy of mothering.

Motives for Working or Not

Although it is understandable that a woman's deep dissatisfaction concerning nonattainment of her own goals may enter into her relationships with her child, it is not so clear why this should have a greater adverse effect in the nonworking than in the working group. A possible explanation lies within the next step of analysis which inquires into the reasons the women made their choice of working or not working, regardless of their expressed preference.

Our findings show that among the working mothers there are differences in major focus, although all mention some kind of economic and personal gains and losses. In one group, comprising 52 percent of the working mothers, the mothers are working primarily as a means of achieving cultural, status, educational, and health goals for the family and children not otherwise available. In a second group (48 percent) the mothers are working mainly to achieve *self-fulfillment*—to use special skills, to make a "contribution to society", to satisfy a need for "being with people."

Among the nonworking women there are three clearly differentiated subgroups: one refraining from work because of *love of mothering* (48 percent); another, out of *duty to mothering* (36 percent); and third (15 percent) because it is "easier" or "freer." The mothers in the third group, however, are similar only in the fact that family and child considerations are not of main concern. The "freedom" they desire may be to follow avocations, community concerns, social ambitions, or simply to indulge their fancies. Because of its heterogeneity, the "freedom" group was not used for further analysis.

In the regrouping of working mothers by family motives and self-fulfillment, and nonworking mothers by love of mothering and duty to mothering, the differences again appear stronger in the nonworking groups. The family-motivated and self-fulfillment groups of working mothers show only slight difference in child-rearing qualities. This may be because the working mothers who would rather not be working, in doing so, are making available certain family-and-child relevant goals which may compensate them somewhat for their dissatisfaction with their work role.

Nonworking mothers grouped by love of mothering versus duty to mother role are, conceptually, more clearly differentiated in feelings toward child rearing, particularly the love-motivated mothers and the "duty" mothers who feel deprived by not working. In this fact would seem to lie the reasons for the differences in mothering by the nonworking mothers satisfied and those dissatisfied with not working. The findings of differences between "love" and "duty" mothers in general parallel the differences between satisfied and dissatisfied nonworking mothers.

Mothers' Educational Background

Although the sample for this study was selected so as to limit variability in social class, a narrow range from middle to upper middle class exists. Also, the mothers' educational background varies. Classifying mothers on the basis of college education or high school education conveniently splits the sample into four very nearly numerically equal working and nonworking groups. The analyses of differences among these groups are explorations not based on prior hypotheses; however, differences were found which are provocative of hypotheses. If work status is ignored, college and high school mothers (within the narrow class range of our sample) do not differ on the child-rearing measures. But when work status and educational level and child rearing are considered together suggestive interactions appear.

Nonworking college, compared with nonworking high school, mothers appear to differ in more ways in child rearing than do working college mothers compared with working high school mothers. In the working groups the only differences are that the college mothers have higher ratings of sensitivity to child's needs and that the high school mothers' families have a greater tendency for fathers to be the stricter of the parents. In the nonworking group the college mothers are more often than the high school mothers rated as nurturing independence, showing sensitivity, being consistent in principles and practice, setting limits clearly, and having higher scores on adequacy of mothering.

These data raise the questions as to whether working may not be selecting certain kinds of mothers, or whether working has the effect of "leveling" social class differences. The mothers of high school background who are using employment as a means of social mobility (more lessons, education, travel for family) may also be altering their child-rearing practices.

A similar question may be raised when the data on working-nonworking differences within each educational group are examined. It is: Do families of different social class backgrounds make different types of adaptations to the mother's working?

Among the families where the mother has a *high school background*, our data shows that when the mother works: the father is more likely to be the stricter parent (70 percent as against 33 percent when the mother does not work); the children are less likely to be regarded as rebellious (10 percent as against 46 percent) but are more likely to be assigned a heavy load of household responsibilities (30 percent compared with 8 percent); and training for independence is more likely to be stressed (80 percent as against 54 percent). In other words, in this group the children of the working mothers are under firmer control and more responsibility is expected of them.

The data for working and nonworking mothers of the *college group* gives a different picture—in some respects tending in the opposite direction. For example, 30 percent and 50 percent of fathers are the stricter parent in working and nonworking college groups, respectively; and 8 percent of the working college educated mothers as against 27 percent of nonworking college mothers put great stress on maturing independence—not a statistically significant difference but still a reversal of the picture in the high school group.

In the families of working mothers in the college group both mothers and fathers apparently attempt to compensate for the amount of time both parents are out of the home by giving planned time together with the child: 40 percent of the college working mothers report this for themselves and report it also for 38 percent of the fathers. The nonworking college group have 16 percent and 8 percent in the comparable categories. In the high school group working and nonworking subgroups are not different in planned participation with children.

The kind of subcultural or class examination that has been carried out here may be extremely important in attempting to pin down what influences the growth in maternal employment may be having on the rearing patterns of large populations of children. It is suggested in these data that the nature of these influences cannot be predicted across the class and cultural boundaries (any more than they can be predicted in disregard of motivational differences among mothers) since it will vary according to values and needs of each group.

Opportunities for Research

This potpourri of differences in the child-rearing practices of working and nonworking mothers related to the variables in the mothers' personal situations should not yet be taken as firm evidence of relationships of specific kinds or amounts. Our groups are small. The variables are complex and need more refinement. But the data can be taken as suggestive of the likely importance of considering such maternal variables more seriously in further research on the interaction of work roles and mother role and in child-rearing studies in general.

When social concern is expressed about the consequences of mothers in the labor force, it is largely an expression of fears about the real and presumed loss of the mother as an effective influence on her children. When the mother works, the basic structure of the rearing environment is presumed altered by the reduction in the mother's availability to the family and by the various systems of child care substituted for the full-time mother. These structural changes afford excellent opportunities for research on significant problems in personality development.

One such problem is the effect of maternal separation. Separation of child from mother is ordinarily a consequence of maternal employment. In theories of development, separation from mother in the child's early years has been interpreted as etiologically significant for various later character disorders. As has been pointed out in the literature,[3] the effects of separation have usually been examined in circumstances of compounded trauma, such as institutionalization or illness. In families without gross pathology, in which the working mother is away from the child, "separation" could be studied in a purer form.

The child's separation from his mother cannot be defined independently of the nature of the mother-substitute. Is the rearing environment one of multiple mothering? Is the replacement for the mother a consistent mother-figure or changing personnel? Do the child's siblings or peer society form the substitute? Is the child on his own? A great many developmental questions are prompted by these mother-substitute variations, all of which can be studied in families of working mothers.

Settings of maternal employment can also provide research material on the effects of variations of mother-father roles upon child personality. Thus, the absolute and relative availability of both parents to the child, the kind of sex role model provided by each parent, the relative dominance of mother and father, the kinds of child-rearing functions assumed by father and mother are dimensions in which there is probably augmented variation by virtue of the mother's employment. Through appropriate sampling of families of working and nonworking mothers, parental role variations pertinent to many theoretical interests could be obtained. In particular, theories of pathological development regarding the dominant mother and "weak" father roles might be investigated in relatively nonpathological families.

Bronfenbrenner[4] has presented findings, based on retrospective data, indicating differential effects of parental absence depending upon whether the absent parent and the child are of the same or opposite sex. These leads could be pursued through more direct data. It would be especially interesting to investigate the consequences of relative parental dominance and availability at significant developmental periods, such as the Oedipal stage, studying boys and girls separately.

To summarize, in most research thus far, the problem of maternal employment and child development has been investigated more as a practical social issue than as an opportunity for gaining more basic understanding of parental contributions to child development. I have attempted here to demonstrate the futility of the "social issue" approach which ignores the necessity for comprehending the psychological and social qualities of the variable of maternal employment. I have also tried to indicate areas in which more theoretically based research, using maternal employment as a setting, could contribute to basic knowledge of the influences in child development.

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[1] Stolz, Lois M.: Effects of maternal employment on children; evidence from research. *Child Development*, December 1960.

[2] Hoffman, Lois: Effect of maternal employment upon the child. *Child Development*, March 1961.

[3] Yarrow, L.: Maternal deprivation; toward a theoretical and empirical reanalysis. Psychological Bulletin. *In press.*

[4] Bronfenbrenner, U.: Family structure and development, Presidential Address, Division of Developmental Psychology, American Psychological Association, Sept. 1958.

TELEVISION AND THE CHILD

ELEANOR E. MACCOBY

Associate Professor, Department of Psychology, Stanford University

"TELEVISION in the Lives of Our Children," by Schramm, Lyle, and Parker, is a sobering book.[1] As the authors say, they have attempted "not to push the panic button on television," and they have been careful, in presenting the results of their own research and that of others, to give a balanced interpretation and to take into account the economic pressures under which the industry must work. Yet the total picture they present is one of lost opportunities at the best, and damage to children at the worst.

A major theme of the book is that TV-viewing is an active process on the child's part. The authors hold that it is not accurate to think of the child as being passively acted *upon* by TV. Rather, they assert, the child actively *selects* from what is offered, and the effects of TV are as much due to what the child is like as to what programs are like. The authors produce sound evidence to demonstrate that a child's use of TV depends upon his intelligence and upon the quality of his relationship with his parents and playmates. There are great differences among children in the amount of time they spend watching TV and the kinds of programs they view. Still, it may be useful to consider the impact of TV on children as a whole.

The book reports that the average child of school age spends about 19 or 20 hours a week viewing TV—about one-fifth of his waking time, nearly as much time as he spends in school, and substantially more time than he spends on all the other communications media combined.

What does he see? The authors monitored a week of TV in a metropolitan area in late October 1960. The chart on page 230 shows what was being offered on the four commercial stations during one day of that week, from 4 p.m. to 9 p.m., the "children's hour."

The authors then chronicled the number of episodes of violence presented during the 100 hours during which they were monitoring the stations: 12 murders, 16 major gunfights, 21 persons shot (not fatally), 37 hand-to-hand fights, and 4 suicides. As may be seen from the sample schedule of programs, there were a good many periods during the day during which a child could not watch anything *except* a western or a crime show, even if he had wanted to do so—nothing else was available. This fact, I think, reduces the importance of their point about the child's being an active selector from television—the fare offered is so limited and homogeneous that frequently the child's only choice lies in the decision to watch or turn the set off.

The Effects

What are the effects upon children of so much viewing of the kind of fare offered? From existing evidence, which the authors summarize, there appears to be little reason to believe that TV-viewing damages children's eyesight or robs them of a significant amount of sleep. Does it educate and inform them?

The authors show that in communities which have television, children start school with about a one-year advantage in vocabulary over the children who live in communities where TV is not yet available. But this difference soon disappears under the impact of the schoolroom, and by the time the children are 10 years old television serves mainly to inform those who see it about the kind of content it emphasizes. TV-viewers of this age, for example, know more than their nonviewing contemporaries about the names of performers and hit tunes, but they know *less* about

THE CHILDREN'S HOUR

One Day's 4–9 p.m. Commercial TV Offerings in a Metropolitan Area

	A Network	B Network	C Network	D Independent
4:00	Crime movie Cartoons	Dance party	Dance party	Cartoons
5:00	Cartoons plus M.C.	War movie	Cartoons Cartoons	Slapstick films
6:00	News Situation comedy	Cartoons	Situation comedy News	Situation comedy Western
7:00	Crime	News	Western	Travel film
8:00	Western	Crime	Situation comedy Situation comedy	Crime Crime
9:00	Western	Documentary		

world affairs. On the whole, TV appears to have little impact, either positive or negative, upon school grade.

From their own and others' research, these authors are able to document some effects of TV on the emotions and beliefs of children. For example, they cite Australian studies which show that crime and mystery programs seem to arouse defensive reactions with which the child protects himself from having to undergo the full emotional impact of the stories, so that adolescents who watch many such programs seem to have become somewhat "desensitized" to the sufferings of others.

With respect to TV's effects on beliefs, there is evidence that children *do* learn stereotypes from television concerning the nature of the adult world and the motives of people around them. For example, adolescent girls who have a heavy diet of the "soap opera" kind of TV programs are more likely than other girls to believe that marriage is a tense and difficult state of affairs and to express anxiety about their own ability to cope with adult life.

How about the effects of the large amounts of crime and violence on the children's own aggressive tendencies? The authors devote a good deal of attention to discussing the charges that have been leveled against TV as a significant cause of delinquency. They hold that delinquent behavior in any given child is a complex phenomenon, with its roots usually in unsatisfactory relationships between the child and his parents. They believe, therefore, that it is entirely misleading to think of television as "the cause" of delinquency. Yet they suggest that, given the existence of children who are disposed to aggressive action because of their life histories, TV can contribute to their antisocial behavior by suggesting techniques for crime. They also suggest tentatively that, even in children who do not come to TV with excessively aggressive feelings, the violence on TV may *arouse* aggressive feelings rather than discharge them.

Since this book was published there have been additional studies which do indeed show a direct connection between viewing violence and ensuing aggressive behavior on the part of the normal young child. Lovaas[2] has recently shown that children who have just seen an aggressive program are more likely to play with a toy which makes one doll hit another on the head than are children who have not seen the programs. And Bandura[3] has found that children who see aggressive behavior in a movie imitate this behavior when they are irritated and when they are in a similar situation to that in which the movie character performed his aggressive actions.

Thus, the case for a direct influence of television on the aggressive behavior of children is now stronger than it was when the evidence was examined by Schramm and his colleagues. These authors do emphasize that it is possible to insulate children (at least in some degree) against the harm which violence on TV may do to them, by helping them to distinguish between fantasy and reality, and by providing them with the emotional security that comes from satisfactory human relationships; but the authors note that less violence on television would also help to protect children from potential harm.

Whose Responsibility?

This book avoids making any sensational charges, but I believe it documents in its understated way that the present television fare being offered to children is unsatisfactory. On the whole, existing programs are *not* challenging and educating children nor providing the sort of variety which might stimulate the growth of taste.

The book concludes with a series of questions to groups who are concerned with the problem of TV's effects on children, questions directed to broadcaster, to parents, to schools, to Government. It is at this point that I was left somewhat dissatisfied. The authors say, "It has been argued that in our political system, Government should keep its hands off programs. On the other hand, it is argued that no agency except Government is big enough to deal with the great mass media. Our position is closer to the first than to the second of these. We prefer that the mass communicators should keep their own house clean."

This is a laudable preference, but is it realistic? I submit that the history of self-regulation on the part of industries which affect the public welfare is not encouraging. Schramm and associates say that "*the very nature of television* makes for a minimum of variety" in offerings which are made available to a youthful audience which needs variety. They do not elaborate on what this "very nature" of television is that they are referring to, but it is likely that they mean the economic pressures to which American television is subject. The most dedicated, public-spirited of producers cannot hold out indefinitely against the pressure of advertisers who want the largest possible audience for their advertising dollar. And one cannot blame either advertisers or station managers for wanting their enterprise to be profitable.

Good children's programs, at present, do not pay. This, it seems to me, is the heart of the problem, and Schramm and his colleagues do not deal with it. To urge as the only major remedial measure that the industry should clean its own house is to assume that the industry as presently organized has more freedom of action than it actually has. The industry may react to pressure and exhortation with temporary and modest improvements and this will be all to the good. But is it enough?

Newton Minow, chairman of the Federal Communications Commission, said in his recent speech to the National Association of Broadcasters:

> Is there no room on television to teach, to inform, to uplift, to stretch, to enlarge the capacities of our children? Is there no room for programs deepening their understanding of children in other lands? Is there no room for a children's news show explaining something about the world to them at their level of understanding? Is there no room for reading the great literature of the past, teaching them the great traditions of freedom? There are some fine children's shows, but they are drowned out in the massive doses of cartoons, violence, and more violence.

Schramm and his colleagues have documented the need for the very improvements which Minow seeks. What is needed now is public policy-making and public action to bring them about.

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[1] Schramm, W.; Lyle, J.; Parker, E. B.: Television in the lives of our children. Stanford University Press, Stanford, Calif., 1961. $6. 324 pp.

[2] Lovaas, I.: Effects of exposure to symbolic aggression on aggressive behavior. *Child Development,* March 1961.

[3] Bandura, A.: Unpublished.

The average man who says "I was well thrashed by my father and it did me a world of good" quite forgets that it did him good because he himself accepted the values held by the chastiser or by the society he represented. But the delinquent, whose whole attitude toward society is conditioned by early separation or lack of emotional support from his parents, has no such inner assent. His attitude toward punishment can only be visualized in terms of a prisoner-of-war resisting and resenting the stern measures of his captors: they may cow him into submission but they can never win him to allegiance.

Society's best protection against the offender is so to win him. It is only by understanding and accepting our own antisocial tendencies—not ensconcing ourselves on judicial benches, in editorial offices, or psychiatrists' consulting rooms—that we can give the delinquent the understanding and acceptance he needs, so that he can accept us and our values and become our fellow citizen.

F. R. C. Casson in The Lancet, *May 5, 1951.*

Social Security Act. Congress is authorized to appropriate $25 million for each of these three programs.

HERE AND THERE

Federal Legislation

A 3-year program of Federal grants-in-aid and technical assistance for the prevention and control of juvenile delinquency or youth offenses was provided for by Congress with the passage in mid-September of the Juvenile Delinquency and Youth Offenses Control Act of 1961.

The act authorizes the Secretary of Health, Education, and Welfare to make grants to State, local, or other public or nonprofit agencies, organizations or institutions, for projects to evaluate or demonstrate techniques or practices which hold promise of making a substantial contribution to the prevention or control of juvenile delinquency or youth offenses, including techniques and practices for the training of personnel and for developing or starting more effective cooperation among public and nonprofit agencies. The act also authorizes grants to Federal, State, local, or other public or nonprofit agencies, organizations or institutions for personnel training programs which may include "among other things" the development of courses of study, and the establishment of short-term traineeships with allowances and subsistence expenses to be determined by the Secretary.

The act also authorizes the Secretary to make studies related to the prevention, treatment, or control of juvenile delinquency or youth crime, to render technical assistance to State and local, public and private agencies, organizations and institutions, and to provide short-term instruction in technical matters relating to the prevention and control of juvenile delinquency or youth offenses.

In administering the act, the Secretary of Health, Education, and Welfare is required to consult the President's Committee on Juvenile Delinquency and Youth Crime on general policy and procedure, and is authorized to appoint technical or other advisory committees. The President's committee, composed of the Attorney General, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, was established last May to promote and coordinate Federal efforts related to the prevention and control of juvenile delinquency and youth crime. (See CHILDREN, July-August 1961, p. 155.) The new law also authorizes the Secretary of Health, Education, and Welfare, at his discretion, to require some of the costs of the projects to be borne by the grant recipients.

Under the act, Congress is authorized to appropriate up to $10 million for the program for each of the fiscal years, 1962, 1963 and 1964. An appropriation of $8,200,000 made for the fiscal year 1962 included $4 million for demonstration and evaluation projects; $3,600,000 for training personnel; and $600,000 for services and administration.

. . .

Congress incorporated into the basic Immigration and Nationality Act, thereby making permanent, most of the previously temporary provisions covering intercountry adoptions. These provisions, allowing alien, eligible orphans into this country on special nonquota immigration visas, had been renewed and modified from time to time, sometimes months after the last expiration date. (See CHILDREN, November-December 1959, p. 233.) A major change in the new law is the requirement that to be eligible for a visa a child adopted abroad must have been observed by the adoptive parents before or during the adoption procedure.

. . .

Appropriations by the 87th Congress for the four grant programs of the Children's Bureau for the fiscal year 1962 totaled over $69 million, more than $17 million above the amount given these programs for the fiscal year 1961. The new figure contains $25 million for maternal and child health services (including $1 million earmarked for special projects for mentally retarded children); $25 million for crippled children's services; and $18,750,000 for child welfare services, topping last year's allocations for these three programs by about $6,800,000, $5 million, and $5 million, respectively. Under the

In addition, and for the first time, the appropriation included an amount—$350,000—for grants for research or demonstration in child welfare, under an authorization enacted last year.

Congress also appropriated $2,668,000 for Children's Bureau salaries and expenses, 7 percent more than for the fiscal year 1961.

. . .

In mid-September Congress extended for 2 years the provisions for aid to education in federally impacted areas, beyond the expiration date of June 30, 1961. The National Defense Education Act, due to expire on June 30, 1962, was also extended for 2 years.

The 11-year-old program of grants for public schools in impacted areas, was designed to alleviate the pressure on school districts from the influx of families of service personnel or of workers on Federal projects. About 3,800 school districts across the country will benefit from the program.

The National Defense Education Act, originally passed in 1958, allows the Federal Government to underwrite specified school and college programs considered useful to national defense, such as the teaching of science and modern languages. (See CHILDREN, November-December 1958, p. 231.)

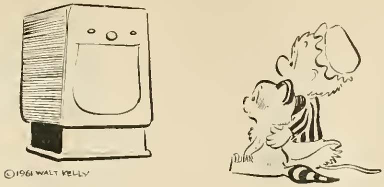
Peace Corps

The Peace Corps became a permanent Federal agency through legislation passed by the 87th Congress in mid-September. The action authorized annual appropriations with a ceiling of $40 million for the new agency's operations. For fiscal 1962, appropriations of $30 million were approved.

By the end of October, the Corps had groups of volunteers in eight countries: In Colombia, there were 62 volunteers and in Chile, 40, working in agriculture and community development; 50 in Ghana, and 38 in Nigeria, in secondary school education; 35 in Tanganyika on road survey and geological assignments; 16 in St. Lucia of the Federation of the West Indies, working in agriculture and youth organizations, and to improve vocational and health education; 128 in the Philippines as teaching aides in English and general science in elementary schools; and 30 in East Pakistan in agriculture, education, and construction work. (See CHILDREN, July–August 1961, p. 153.)

Volunteer groups undergoing training during September and October included 50 at the University of California at Los Angeles, scheduled to leave in January for service in Nigeria in secondary school teaching and 35 at Michigan State University, due to leave for Nigeria in December for work in education at college level. There was also a group of 30 training at Colorado State University for assignments to West Pakistan to work in nursing, agriculture, medicine, and college level teaching, beginning in December; and another 63 studying at Pennsylvania State University for work in the Philippines as teaching aides, to start in early January.

Training projects begun in October included a group of 25 scheduled to leave in December for India to work in experimental agriculture, community development, and small craft industries; 50 at the University of Michigan destined for Thailand to participate in college and technical and trade school instruction and in malaria eradication; and 50 at Northern Illinois University bound for Malaya where, in January, they will begin working in laboratories, in schools as science teachers and apprentice instructors, and in villages as rural development workers.



"TV watching could be a normal part of a balanced whole. Just like radio, comic books, formal education, and love . . . Also milk," says Walt Kelly creator of the "Pogo Primer for Parents (TV Division)," recently issued publication of the Children's Bureau. In the 24-page pamphlet the cartoonist uses Pogo and his family and friends to suggest that patient supervision and shared TV viewing (as in the cartoon above) are preferable to using the TV set as a baby-sitter. One of a Headliner Series of booklets to be issued by the Bureau on topics underscored by the Conference, the primer is available from the U.S. Government Printing Office, Washington 25, D.C., price 20 cents, with 25 percent deduction for quantities of 100 or more.

Other publications in the series soon to be released are: "A Creative Life for Your Children," by Margaret Mead; "Our Mobile Families," by Margaret A. Hickey; "The Adolescent Under Stress," by Edgar Z. Friedenburg.

Handicapped Children

Roughly one-sixth of the estimated 6 million handicapped children of school age in this country are receiving special educational help, according to information from the Office of Education, U.S. Department of Health, Education, and Welfare.

Among other facts on special education today, the Office of Education reports that:

- About 4,000 public school systems provide special educational opportunity for handicapped children—as compared with 1,400 school systems in the late 1940's.
- Every State offers some special educational opportunity to exceptional children.
- Nearly every State education agency has an education specialist for one or more types of handicap; some have as many as 15 specialists.
- About 3,000 local public school systems now have programs for educating mentally retarded children in special classes of regular schools. Nevertheless, only about one-fifth of the estimated 1,250,000 or more mentally retarded children of school age in this country are receiving special education.
- Of the estimated 35,000 deaf children, about 25,000 are in special classes in public schools or in residential schools.
- About 2 million children of school age have speech handicaps, one-fourth of whom are receiving speech correction in public schools.
- In addition to the special schools for crippled children which exist in some 40 large cities, there are many special classes for such children. California has a statewide system with two residential schools with diagnostic services and about 50 smaller centers for cerebral palsied children in regular public schools.
- About 10,000 blind children are in residential schools or in specialized day school programs.

Rehabilitation

A new approach to helping handicapped mothers in the aid-to-dependent-children program—through "all-round" rehabilitation service in a residential training center—is being explored in a pilot project now underway in the District of Columbia. Launched in April 1961, the project has mobilized the resources of community agencies to provide social, vocational, placement, and other services to a group of eligible mothers who were moved with their children out of their old environments into the training center.

The project services are available to mothers between the ages of 18 and 36 years of age who have no more than 2 children under the age of 10. However, the project's vocational services are not provided to mothers who have serious physical, mental, or emotional disabilities.

Under the operation of the District's public welfare department in cooperation with other district agencies, the project gives training for 4–6 months to mothers residing at the center. This includes classroom instructions in home management by teachers from the Board of Education; instruction in personal hygiene, health consultation, and followup by public health nurses from the Department of Public Health; recreational activities for mothers and children by the recreation department; vocational services, assessment of vocational potentials, and actual work training and experience, by the Department of Vocational Rehabilitation. Also available are physical restoration services and medical treatment or hospital care. The U.S. Employment Service counsels and helps place the mothers on jobs after which the National Capital Housing Authority assists in finding suitable living quarters in public housing developments.

During training, the mothers contribute, from their ADC payments, their estimated food and rental costs at the center. The welfare department provides operating and social service staff. A vocational counselor, a training assistant, psychological services and training equipment are provided for the first 3 years by a grant from the U.S. Office of Vocational Rehabilitation.

In the first training session, 32 mothers and 56 children were housed in the center. Of these, 30 mothers had been trained, were placed in jobs, and had left the relief rolls by October 1.

Juvenile Delinquency

About 514,000 juvenile delinquency *cases* (excluding traffic offenses) were handled by juvenile courts in the United States in 1960. The estimated number of different *children* involved in these cases was somewhat lower, 443,000, since the same child may have been referred more than once during the year. These children represent 1.8 percent of all children aged 10 through 17 in the country.

In 1960, for the 12th consecutive year, delinquency cases increased over the previous year. The increase for 1960 for delinquency cases was 6 percent, while the child population, aged 10-17, increased only 2 percent. Thus, as in every year in the past decade except 1959, the increase in delinquency cases exceeded the increase in the child population.

School Enrollment

Enrollment in the Nation's schools and colleges for 1961–62 climbed to a new high of 49,300,000, according to estimates from the U.S. Office of Education. This figure represents a rise of almost 3 percent over last year's total. Enrollments in kindergarten and elementary schools were estimated at 34,200,000—an increase of 400,000 over last year—and at 10,800,000 in high schools, 700,000 more than before.

These upward trends in kindergarten, elementary, and secondary school enrollment are attributed chiefly to rises in birth rates during the past 15 years, but in the case of mounting college enrollment, credit is given to growing interest in college education. The agency anticipates the first sharp rise at this level of education to occur in 1965, reflecting the swollen birth rate in 1946.

The agency's biennial survey of State school systems shows a 22 percent rise in the number of high school graduates in 1959–60 over the total for 1957–58, with a higher proportion of girls than boys, as in previous years. It also shows that the classroom shortage in the Nation at the start of 1960–61 was 142,000, on the basis of State-determined teacher-pupil ratios and other standards, representing a drop of 1,000 from the figure for the 1957–58 school year. The survey also shows a decline in the number of 1-teacher schools—20,000 in 1959–60, a third of the number in 1949–50. Though their national total is negligible, these schools constitute 22 percent of all elementary schools in the Great Lakes-Plains area.

On the basis of daily attendance in schools from kindergarten through grade 12, the expenditure per pupil among the States in the school year 1959–60 was $376, compared with $341 in the year 1957–58.

International Publications

DISCUSSIONS ON CHILD DEVELOPMENT: the proceedings of the fourth meeting of the World Health Organization Study Group on the Psychobiological Development of the Child, Geneva, 1956. J. M. Tanner and Barbel Inhelder, editors. International Universities Press, New York. 1960. 186 pp. $5.

The way biological, psychological, and cultural influences channel the development of personality through childhood was examined by the group of 12 international experts, whose discussions are recorded in this volume.

Springboard for the discussions was a precirculated paper by Jean Piaget synthesizing the themes of previous discussions.

Deliberations of the group at this fourth meeting, which included representatives from the fields of psychology, psychoanalysis, anthropology, electrophysiology, human biology, ethology, and research promotion, dealt with such subjects as equilibration and the development of logical structures; the definition of stages of development; psychosexual stages of development; and a "general system theory" as it is applied to the behavioral sciences.

THE INFLUENCE OF THE CINEMA ON CHILDREN AND ADOLESCENTS; an annotated international bibliography. Reports and papers on mass communication, No. 31. UNESCO, Paris. 1961. 106 pp. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27. $1.50.

This bibliography presents 491 brief abstracts of studies made in 30 countries, dealing with the influence of films on children and adolescents. Most of the publications appeared between 1930–59, though a few earlier ones are included which had direct bearing on subseqent research. Made by experts in the fields of education, sociology, criminology, psychology, psychiatry, and physiology, they are concerned with such subjects as the attitudes of young people toward films, an analysis of film content in relation to reality, the aftereffects of films, and efforts toward helping young people to select films judiciously.

An introduction points out that while the evidence is conflicting in regard to the direct relationship of films to juvenile delinquency, the majority of the authors believe that repeated presentation of certain themes and behavior patterns has an indirect provocative effect on the young viewer. It also calls attention to findings which stress the unreal conception of life derived from the cinema's tendencies toward repetitious portraying of fairytale patterns of living.

AMONG THE STATES

Among the many actions concerning children taken by the legislatures of 47 States and 3 United States jurisdictions which met in 1961 were the following:

Aid to Dependent Children

Twelve States revised their laws providing for aid to dependent children to include the **children of unemployed parents**, thus taking advantage of the new temporary provision in the Social Security Act (see CHILDREN, July–August 1961, page 154). They were *Connecticut, Delaware, Hawaii, Illinois, Massachusetts, New York, North Carolina, Oregon, Pennsylvania, Utah, Washington*, and *West Virginia*.

Other actions relating to ADC were: *Connecticut* dropped its 1-year residence requirement; *Indiana* authorized counties to provide vocational training for mothers receiving ADC; *New York* required public welfare officials to look into the eligibility of public assistance recipients recently arrived in the State in relation to their intent in coming into the State, including "willingness to work." *New York* also set up a central agency in the State department of social welfare to aid in locating fathers who have deserted children receiving public assistance or care. *Washington* devised a method for designating a person to receive a child's ADC grant in cases where the county welfare department decides the normal recipient is not using the grant wisely.

Delinquency and Neglect

Court systems were revamped in: *Georgia* where superior court judges were empowered to sit as juvenile court judges in counties with populations ranging between 130,000 to 300,000; *Maine* where new district courts which are to act as juvenile courts were established; and *Rhode Island* where a family court was created combining the former domestic relations and juvenile courts. In *Massachusetts* the legislative research unit was directed to study the desirability of establishing a juvenile court system for the State.

Detention of juveniles awaiting court action was a concern in: *Kansas* where the separate detention of juveniles and adults became a requirement; *Minnesota* where a reception center for delinquents was authorized; *Utah* where counties were made responsible for providing detention facilities, with State aid, and a State advisory committee on detention was established; *South Dakota* where counties without detention facilities were authorized to contract for them with other counties.

Work programs for juvenile offenders were provided for in *Colorado*, where county courts were given the power to establish guided work programs that do not interfere with school attendance; and in *Missouri* and *Tennessee* where conservation camps in connection with the boys' training schools were authorized.

Other provisions to combat delinquency were: in *Maine* an appropriation to increase the staff for supervising boys released from the State training school; in *Nevada*, provision for a training school for delinquent girls, and authorization for the welfare department to pay for the foster care of young people paroled from the State's training schools and unable to return home; in *Pennsylvania*, an appropriation of $756,000 for a delinquency prevention program including grants to communities for local programs and for salaries of police specializing in juvenile crime prevention; in *South Dakota*, the exclusion of traffic offenses from juvenile court jurisdiction.

The Interstate Compact on Juveniles was adopted by *Idaho, Iowa*, and *South Dakota*.

Adoptions and Foster Care

Adoptions received considerable legislative attention, with adoption laws being amended or other actions taken:

In *Georgia*, to preserve the rights and obligations of a natural parent in regard to a child adopted by the parent's spouse.

In *Missouri*, to eliminate the necessity of serving summons to parents in abandonment cases when consent for adoption is already on file.

In *Nevada*, to make funds available for an investigation of illegal or unethical practices in child placement or adoption; to require consent to adoption to be in writing attested by two witnesses and filed within 48 hours; to prohibit adoption petitions from being granted until after the child has been in the petitioner's home in the State for 6 months; and to require hospitals to give the welfare department a copy of the authorization when a child under 6 months old is released to someone other than a parent, guardian, or close relative.

In *New Mexico*, to provide procedures for freeing for adoption children declared dependent and neglected who have been wards of the court for at least 6 months; and to enable social agencies to consent to the adoption of children so freed.

In *New York*, to make it possible in private placement adoptions for the home investigation to begin immediately upon placement of the child; and to permit the court, as a part of the adoption procedure, to remove the child from the home where it appears improper to grant the adoption order.

In *North Carolina*, to redefine "abandonment" in order to free children for adoption.

In *North Dakota*, to require notice of termination of parental rights to be sent to the father of an illegitimate child if paternity has been acknowledged; to allow a child placing agency to charge adoptive parents up to $300 for the costs of the home investigation and child supervision, with the proviso that no couple be deprived of receiving a child because of inability to pay the costs.

In *Tennessee*, to clarify the term "abondonment"; to waive residence requirements for prospective adoptive couples from the State who are in military service; and to allow filing of a final decree 6 months after petition if a child has lived for a year in the petitioner's home and was placed there by the department of welfare or a licensed agency.

Measures affecting children in foster care included:

In *Kansas*, a provision for appeals from orders of the State Board of Health denying or revoking licenses for maternity homes, children's institutions, and foster homes.

In *North Dakota*, a change making it discretionary rather than mandatory to match religions of foster home or institution and child's parents, in placing a child.

In *Wyoming*, an action transferring the licensing of child-care facilities to the State Department of Public Welfare from the Board of Charities and Reform, extending licensing requirements to foster family homes, and directing the department to draw up standards for all types of foster care.

The day-care needs of children of working mothers received attention in *Massachusetts* where a special commission composed of representatives of day-care agencies was authorized to make a study of the needs for this type of service; and in the *Virgin Islands* where an appropriation of $35,000 for the operation of day-care facilities represented an increase of $10,000 over the previous appropriation.

Exceptional Children

Institutions for mentally retarded children were provided for in *Florida*, *Illinois*, and *Iowa*, and for emotionally disturbed children in *New York* and *Minnesota*. In *Arizona* funds were supplied for two 80-bed cottages at the State Children's Colony in Coolidge.

Special education programs for handicapped children were provided for in a number of areas. In *Alaska* and *Guam* appropriations were made to parents' organizations for special training of trainable or educable mentally handicapped children. In *Arizona* and *North Dakota* school districts were authorized to provide special classes for the educable handicapped. In *Montana* it was made mandatory for school districts to provide special education for the physically and mentally handicapped, reimbursement to be provided by the State for tuition and transportation. In *New York*, local boards of education were authorized to provide educational programs and transportation for emotionally disturbed children. In *North Dakota* it was made mandatory for school districts to make arrangements with private nonsectarian organizations for the education of physically handicapped children for whom no public facilities are available.

The gifted received attention in *California*, *Oregon*, and *Puerto Rico* where appropriations were made to enhance their educational opportunities.

Mental retardation studies as a source of recommendations for the next legislature were authorized in *Iowa* and *New York;* and in *California* a coordinating council was established to review, coordinate, and make legislative recommendations for services for the physically and mentally handicapped.

Other provisions for the mentally handicapped included: in *Illinois*, a special pediatric institute for their study and care; in *Maryland*, State funds to match community expenditures for special day-care centers; in *Minnesota*, a pilot project to provide them with daytime activities; in *Oregon*, payments (up to $100 a month) to their parents for their maintenance or training in a day center or group training home (this also applies to parents of the "physically deficient"); in *Utah*, an increased appropriation for special day-care centers.

Definitions of "crippled children" were revised in some States to bring more children into State programs for diagnosis and treatment: children with cystic fibrosis were thus included in *California*, as were children with phenylketonuria; and mentally handicapped children in *Nevada* and *Tennessee*. Funds were earmarked for the care of quadriplegics in *Connecticut*, and for a rheumatic fever prophylaxis program in *Massachusetts*. In *Indiana* the testing of infants for phenylketonuria was made mandatory throughout the State. In *North Carolina* the biennial appropriation for crippled children's services was 47 percent above the previous appropriation.

Other Programs

Work opportunities for youth were provided for in a number of States:

In *Hawaii*, where the sum of $45,000 was earmarked for the expenses of an experimental school-work-experience program for young people who intend to leave or who have left school before graduating; and in *Idaho*, *Oregon*, and *Washington*, which established summer work-camp programs for teenagers. In *Tennessee* workmen's compensation was extended to minors even though unlawfully employed.

Migrant children and their parents received attention in: *California* where a health program for migrant workers and their families, under the State department of health, was prescribed to include studies of health and health services, technical and financial aid to local health agencies serving migrants, and coordination; and in *Colorado* and *Oregon* where programs for the education of migrant children were spelled out. In *Colorado* where school districts are to be reimbursed for the costs of educating migrants, school attendance of migrant children was made compulsory as was admission of migrants to public schools.

Structure and Coordination

Changes in administrative structure and the creation of coordinating committees were numerous:

In *Arizona* the crippled children's services were moved from the Department of Public Welfare into a new Board of Crippled Children's Services. The 5-member board is authorized to apply for Federal funds for crippled children's services.

In *Illinois* a Department of Mental Health was created to supersede the State Department of Public Welfare, the child welfare program being moved into the new department.

In *Indiana* a separate Department of Mental Health was established.

In *Iowa*, an interagency liaison committee was created to coordinate activities of the Boards of Control and Parole, the State regents, and the State agencies concerned with welfare, public health, education, vocational rehabilitation, and employment security.

In *Missouri* the powers and duties of the division of welfare in the State Department of Health and Welfare were enlarged with the responsibility for promoting and protecting the well-being of children, strengthening family life, preventing dependency, and rehabilitating needy persons, and for conducting research and demonstration projects related to the welfare program.

In *Nebraska* the functions of the State Board of Control were transferred to newly created departments of public welfare and public institutions, with a 5-member advisory group serving both agencies. The Department of Public Welfare will be responsible for the public assistance, child welfare, and the crippled children's programs as well as for custody of children in State institutions and operation of the Home for Children. The Department of Public Institutions will oversee and generally control the training schools for girls and for boys, State hospitals, and penal institutions.

In *Nevada* a bureau of mental health was established within the State Department of Health.

In *Oklahoma* the four State institutions for delinquent boys and girls and the two institutions for dependent and neglected children were moved from the Board of Public Affairs to the Department of Public Welfare.

In *North Dakota* the children's psychiatric out-patient clinic was transferred from the Board of Administration to a new State mental health authority established within the State Department of Health; and a mental health coordinating committee was created composed of the State health officer, the superintendent of public instruction, the executive director of the Public Welfare Board, and the chairman of the Board of Administration.

In *Rhode Island* certain health-related responsibilities in the Department of Education were transferred to the State Department of Health to be carried out in conjunction with the Department of Education.

In *West Virginia* the Department of Public Assistance was renamed the Department of Welfare, and the position of director changed to commissioner. The department's appropriation allowed for salary increases averaging 17 percent for professional workers, and for the employment of additional personnel, including foster- and adoptive-home finders in all counties.

Studies of structure and services were ordered in a number of States including:

Colorado, where the Legislative Council was authorized to appoint a special committee to continue study of laws relating to children and child welfare.

Idaho, where an 11-member body, the Idaho Children's Commission was established, to study and make legislative recommendations concerning the State's laws and resources for delinquent, dependent, abused, and neglected children and youth, the State's adoption laws, and the laws and resources concerned with the evaluation, rehabilitation, and care of mentally and physically handicapped children.

Pennsylvania, where a 13-member commission was created to draw up a plan for dividing public welfare responsibilities and functions between State and counties and for organizing county public welfare services; to collate the bulk of the State's welfare statutes relating to public and private facilities; and to recodify laws and propose new ones.

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

MEDICAL GENETICS—Part I. 34 minutes; sound; color; loan.

Depicts the historical development of genetics, the physical basis of inheritance, and some chromosomal abnormalities in man.

Audience: Medical and nursing students; students interested in biological sciences at the college or postgraduate level and advanced high school students.

Produced by: Johns Hopkins University School of Medicine, Department of Medical Genetics.

Distributed by: National Foundation, 800 Second Avenue, New York 17.

RESUSCITATION OF THE NEWBORN. 25 minutes; sound; color; loan.

Shows through actual deliveryroom resuscitations the procedures and apparatus necessary for effective resuscitation of newborn infants who do not breathe, or whose respiration is impaired, at birth.

Audience: Physicians and nurses in maternity services.

Produced by: Sturgis-Grant Productions, New York.

Distributed by: Smith, Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia 1, Pa.

JOURNEY IN HEALTH. 22 minutes; sound; color; rent or purchase.

Stresses the importance of preventive medicine among children through regular and continuous health supervision by a family physician.

Audience: Parents; parent-teacher associations.

Produced by: The Smart Family Foundation, in cooperation with the American Medical Association and the American Academy of Pediatrics.

Distributed by: For rental, the American Medical Association, 535 North Dearborn Street, Chicago, Ill., and the American Hospital Association, 18 East Division Street, Chicago, Ill. For purchase, the Smart Family Foundation, 65 East South Water Street, Chicago 1, Ill.

FOUR FAMILIES—Parts I and II.

30 minutes; sound; black and white; purchase.

Part I shows child-rearing practices and parent-child relationships in farm families of India and France; part II, in Canada and Japan. Each family includes a year-old baby as well as one or two other small children. Dr. Margaret Mead, the commentator, points to some distinctive features of handling the baby, implying that they may have important effects on personality and character development.

Audience: Any audience interested in children, especially PTA groups and mothers of very young children.

Produced by: National Film Board of Canada.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36.

BOOK NOTES

THE TWENTY BILLION DOLLAR CHALLENGE—A National Program for Delinquency Prevention. Kenyon Scudder and Kenneth Beam. G. P. Putnam Sons, New York. 1961. 236 pp. $4.50.

The title of this nontechnical book is based on an estimate of the annual cost to taxpayers of crime and delinquency. While the authors do not claim that most of this enormous cost can be saved, they call for application of money and manpower to preventive efforts as the most promising way of bringing the mounting costs of delinquency and crime under control.

The basic purpose of this book is to create citizen awareness that the primary responsibility to prevent delinquency rests with them—that what they do or do not do in their own homes and communities can be crucial in preventing or fostering delinquency. In indicating how citizens can meet their responsibility, the book gives major emphasis to cooperative effort through coordinating or community councils, though it acknowledges that the formation of a council can be only a partial approach to the solution of the delinquency problem. The numerous council accomplishments it cites are drawn largely from the experience of coordinating councils in California where they are most widespread.

PARENTS OF THE HANDICAPPED; self-organized parents' and relatives' groups for treatment of ill and handicapped children. Alfred H. Katz. Foreword by Gunnar Dybwad. Charles C. Thomas, Springfield, Ill. 1961. 155 pp. $6.

Who will guide the growing number of self-organized groups for parents of the handicapped? Can these emotionally involved groups contribute objectively to community welfare? These are among the questions which the author attempts to answer in this book about what he calls a new type of voluntary social agency, drawing dynamism from the parents' urge to counter defeatism and isolation with group action.

The author, who is associate professor of social welfare in medicine at the University of California at Los Angeles, first sketches the main lines of the evolution and structure of four separate parent organizations, subsequently analyzing and comparing parent participation according to motivations, values, and composition. A later chapter treats the common elements in the growth and in the staffing patterns of such parent groups.

He finds these groups can work well with the central planning agencies of the community, especially on blueprints for fund raising and services, but warns professional social agencies against setting standards for such lay groups without adequate interpretation.

RACE AND SCIENCE: the race question in modern science. Columbia University Press, New York. 1961. 506 pp. $5.

That the concept of innate racial superiority is "fundamentally antirationalist" and conflicting with "the humanist tradition of the West" is variously expressed in this volume of 11 essays, affording a many-faceted look at the subject of race through the eyes of anthropologists, psychologists, historians, and geneticists. Previously published separately in the UNESCO series of brochures called "The Race Question in Modern Science," the essays draw on contemporary scientific evidence in scrutinizing, for example:

- The origin, development, and "justification" of the most prevalent racial myths, naming among the roots of racial prejudice, personal advantage, and ignorance or the equation of cultural differences with inferiority.
- The relation of race to society, historically and as demonstrated in South Africa, Brazil, Hawaii, and Great Britain.
- Race and culture, defining the scope of race as differentiated from culture, religion, and linguistic entity.
- Race and biology, including genetic and environmental aspects.

"Is prejudice inevitable?" asks psychologist Marie Jahoda, one of the contributors, who describes the failure of rational or satirical efforts to change prejudice against outgroups. Describing such prejudice as the product of inadequate reality testing, in most cases, and as a psychological defense against the bearer's inner weaknesses, the author suggests that success in eliminating prejudice through personal contact, as in integrated housing, serves to destroy the ability of the prejudiced to misconstrue reality, even though it does not effect a personality change.

HEALTH EDUCATION: a guide for teachers and a text for teacher education. Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the cooperation of contributors and consultants. Bernice R. Moss, Warren H. Southworth, and John Lester Reichert, editors. National Education Association of the United States, Washington, D.C., 1961. 429 pp. $5.

First presented in 1924 as a joint venture of physicians and educators in health education, the book has been rewritten in this fifth edition to serve not only as a sourcebook for teachers in schools and as a text for teacher education, but also as a reference for all the professions dealing with school health. In addition to covering basic problems of teaching health at all grade levels, including attitudes and behavioral changes, the book's 16 chapters also offer guidance in curriculum, materials and resources, and evaluation in health education.

HUMAN PSYCHOLOGICAL DEVELOPMENT. Elizabeth Lee Vincent and Phyllis C. Martin. The Ronald Press Co., New York. 1961. 522 pp. $6.50.

At the outset, the authors of this textbook, a psychologist and a biologist, state their thesis: the psychological self exists only in the body; and there is reciprocal interplay between the intellect and personality and the body. The book then presents information on each sequence of human growth—from prenatal life through adulthood—and supplies interpretive comments, flavored with the authors' personal philosophies of life, followed by advice on the ways of reaching a coordinated, mature adulthood.

The authors are on the faculty of Chatham University, in Pittsburgh.

EMOTIONAL FACTORS IN PUBLIC HEALTH NURSING. A casebook. Abraham B. Abramovitz, editor. Introduction and concluding chapter by Louis H. Orzack. The University of Wisconsin Press, Madison. 1961. 171 pp. $4.

In his introductory comments in this casebook, Louis H. Orzack, a sociologist on the faculty of Boston University, points out that the public health nurse carrying out her professional decisions is not buttressed by institutional controls as are physicians, teachers, and lawyers, but must depend on persuasive communication. This resource can be enhanced by the nurse's familiarity with the dynamics of behavior, he adds.

To give the public health nurse this familiarity so that she can also understand herself and co-workers better, the book offers nine case stories from the files of public health nurses, compiled by the Bureau of Maternal and Child Health of the Wisconsin State Board of Health. In addition to illustrating major concepts of emotional health, they show the nurse's involvement and the need to clarify her role in a given situation.

NEIGHBORHOOD CENTERS TODAY; action programs for a rapidly changing world. Arthur Hillman. National Federation of Settlements and Neighborhood Centers, New York. 1960. 239 pp.

Scanning a cross-section of the Nation's settlement programs, the author explores the ways in which they are meeting the challenges of change, particularly those posed by "the kaleidoscopic movement of population from country to city, from city to suburbs, and among different parts of the country."

According to the author, who is professor of sociology and dean of the College of Arts and Sciences of Roosevelt University (Chicago), this mobility, accompanied by personal and social disruptions, can erode the bases of democracy—the understanding, responsibility, and participation of the individual citizen.

Citizen participation is among the book's major chapters which, through illustrative case stories and explanatory texts, record the work of over 60 centers in 25 cities visited by the author.

Other topics include service to families with many problems, special youth services, interracial and intercultural programs, services to older adults, and new forms of association between settlements and public organizations.

READERS' EXCHANGE

CLEMMENS: *A neglected subject*

In his article, "Minimal Brain Damage in Children," Dr. Raymond L. Clemmens [CHILDREN, September–October 1961] brings up a subject of extreme importance to the many professional persons now working in mental retardation clinics. The author's figure of 19 percent of the cases studied in the Maryland Diagnostic Clinic coming under this classification is probably comparable to figures of other clinics.

It seems rather appalling that a condition as prevalent as this has not received more attention. A number of persons have described the condition and a few have written about specific aspects of it, but little research has been focused on it compared with that directed toward many of the other comparatively rare conditions seen in the field of mental retardation. Phenylketonuria, for instance, has received a great deal more attention than the problem of brain damage, although the former is encountered comparatively rarely. The etiology of brain damage, methods for diagnosis, and effective methods for working with the large number of children with the condition have hardly begun to be studied.

Dr. Clemmens' comments on the lack of effective interdisciplinary efforts, the number of children being placed in inappropriate therapeutic programs, the confusion existing between psychiatric and nonpsychiatric handling, dependence on and lack of help from neurological and other conventional medical diagnostic procedures all indicate the tremendous need for extensive coordinated study of the problem.

Robert W. Deisher, M.D.
Director, Division of Child Health, University Hospital, University of Washington.

Diagnostic refinements needed

Anyone with a considerable body of clinical experience in the evaluation of aberrantly developing children must share Dr. Clemmens' conviction that a large proportion of these patients are suffering from some variety of cerebral damage without any specific neurological signs. However, it is only fair to say that this conviction is based entirely on behavioral evidence, and that any attribution of a cause for such dysfunction to minimal brain damage is entirely presumptive. Attaching the adjective "minimal" to the diagnostic designation "brain damage," in no way constitutes a refinement in diagnosis. Rather, it tends to convert our minimal knowledge of the nature of the neurologic deficit into a term applying to the extent of damage which may exist.

One could just as well speak of diffuse, nonspecific cerebral damage or cerebral damage unaccompanied by localizing neurologic signs. But little benefit attaches to the substitution of diagnostic labels when the essential problem of the independent identification of the central nervous system lesion or population of lesions remains to be solved.

It is clear from Dr. Clemmens' discussion that the patients he is considering constitute a population with a heterogeneous array of disabilities. The disorders described range from the classical Bradley-Strauss syndrome of hyperkinesis, organic drivenness, disordered perception, impaired concentration, cognative disturbance, and marked distractability, to a specific subject disability such as an incapacity to read or to learn numerical skills, in relatively normal, well functioning individuals. It is most doubtful whether a common set of neuropathologic disturbances exist in such a heterogeneous group of defective functions. While neurologic disturbances probably underlie all of these dysfunctions, nothing is gained by grouping them into a single neuropathologic entity entitled "minimal brain damage."

What still remains to be done is to separate identifiable specific, homogeneous patterns of disability from the overall population of so-called organically handicapped children. Once such homogeneity of disturbance is achieved, it will be possible to explore in detail the specific behavioral functions that have in fact developed in a disordered manner. Such an analysis can be productive of neuro-pathologic hypotheses that are investigable, by means of more sophisticated refined techniques than are at present available in clinical practice.

Only after such exploration will we be able to attribute neurologic causes and to understand the mechanisms underlying the behavioral disturbances of a complex kind which we at present observe in clinical work. It may be argued that the use of the term "minimal brain damage" to cover all such disturbances of a nonpsychodynamic or nonpsychosocial origin creates an illusion of understanding which may in itself inhibit serious study of the problems at issue.

Herbert G. Birch, M.D.
Associate Research Professor, Department of Pediatrics, Albert Einstein College of Medicine, Yeshiva University.

Author's comments

It is apparent that Dr. Birch has encountered children with the kind of handicaps described in our paper and, moreover, that he agrees with the central concept presented, namely that "neurologic disturbances probably underlie all of these dysfunctions." In regard to his comment that nothing is gained by grouping these heterogeneous conditions under a single heading, it should be pointed out that the professional journals are filled with communications which purportedly establish that these behavior, language, and learning problems are caused wholly by psychocultural factors. Therefore, it seems important to emphasize the underlying biologic basis (or bases) for these conditions.

With the clinical and laboratory techniques now available we are unable to distinguish between brain damage, per se, and brain dysfunction from causes other than tissue destruction. There can be no valid disagreement about the vital importance of separating and defining the many and varied factors which contribute to this complex. From the point of view of intervention, however, either by therapist or teacher, little obvious benefit accrues from a rigid subdistinction between neuroanatomic and neuro-physiologic disturbance.

We have found that children whose major problem is that of markedly disorganized and hyperkinetic behavior (Strauss syndrome) frequently have language problems and unusual difficulty in mastering the basic academic skills. Youngsters whose major problems are neuro-psychiatric learning disorders not infrequently have behavioral characteristics which are difficult to distinguish from the Strauss syndrome and at times from juvenile autism. We have also observed that children with delayed speech development, serious articulatory abnormalities, and auditory perceptual and discrimination problems may be expected to have pronounced difficulty in learning to read, even after the speech and language handicaps have been largely compensated for.

In my view these behavior, language and learning disorders can be caused by a variety of prenatal, perinatal, and postnatal states as well as by developmental deviations which are probably due to genetic transmission. In many instances it is not possible to distinguish between constitutional and acquired cause, thus further complicating the problem of meaningful designation. When our diagnostic studies point to "organicity" and there is no convincing evidence of (acquired) insult to the brain, we use the term "cerebral dysfunction."

In stating that our convictions are based entirely on behavioral evidence, Dr. Birch presumably defines the term "behavioral" in its broadest sense and thereby includes all behavioral sciences. It is obvious to us that any one professional person (pediatrician, psychologist, neurologist, educator, or psychiatrist) is hard pressed to define accurately many of the more subtle deviations of behavior and learning performance. No one can work to optimal advantage in isolation when dealing with the clinical or research aspects of these problems. Again the necessity of a multidisciplined assessment is emphasized.

We have relied heavily upon the skills and techniques of experienced clinical psychologists, audiologists, and speech pathologists. Psychological investigation includes: achievement tests, Bender Gestalt (and other tests of visuo-motor functioning), Rorschach, Wechsler Intelligence Scale for Children, Goodenough-Draw-a-Person and the Lincoln Oseretsky test of motor performance. The electroencephalogram has provided additional valuable information but in our experience has not been as sensitive as psychological testing. Psycho-galvanic skin resistance audiometry has been helpful especially in the evaluation of serious central language and central auditory disorders. The importance of a searching family history, detailed development history and neurologic examination needs no elaboration.

The suggestion that the terms used or the points of view expressed in the article may inhibit serious study is unrealistic. There can be no question of the need for intensive investigations (epidemiologic, genetic, psychologic, neuro-chemical, educational, and histopathologic) in these important areas, where one of the few important points of universal agreement is that we know so little about them.

As these researches proceed, it may be hoped that the professional persons who encounter these children will be aware of the complex nature of their handicaps and the neurologic dysfunctions, which underlies them. The implementation of optimal programs of management requires that this be so.

Raymond L. Clemmens, M.D.
Director, Children's Evaluation Clinic, University Hospital, University of Maryland.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

PROGRAMS OF THE FEDERAL GOVERNMENT AFFECTING CHILDREN AND YOUTH. A summary prepared by the Interdepartmental Committee on Children and Youth. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 55 pp. 50 cents.

This bird's-eye view of all Federal programs concerned with children and youth as of January 1961, is designed for use in followup of the White House Conference of 1960, as the original 1951 publication, of which this is a revision, was used following the midcentury Conference. Also included is a brief résumé of the Federal Government's international activities for children.

CHILD WELFARE STATISTICS 1960. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 60. 1961. 28 pp.

A tabular presentation, with a summary of highlights, of statistics on children receiving child welfare services from public agencies at State and local levels and from voluntary agencies; on personnel in these public agencies; and on selected expenditures for public child welfare services. The total of 382,000 children reported to be receiving public child welfare services on March 31, 1960, included 8,000 in a category not reported before: those receiving special children's services for whom the cost of service is charged to public assistance funds. The report reveals that during fiscal 1960 State and local public welfare agencies spent $211,100,000 for child welfare services, a 14 percent rise over fiscal 1959.

RESEARCH IN CHILD WELFARE. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 389. 1961. 25 cents.

Reporting on a conference held in Washington, D.C., in mid-December 1960, to advise the Children's Bureau on ways of administering funds for research and demonstration projects in child welfare authorized by a 1960 amendment to the Social Security Act, this publication summarizes the major points stressed in the discussion and presents, with some condensation, the verbatim minutes of the conference's four sessions. An appendix lists those research and demonstration projects mentioned as needing attention.

SCHOOL HEALTH PROGRAM; an outline for school and community. Department of Health, Education and Welfare, Public Health Service, Office of Education, and Social Security Administration, Children's Bureau. PHS Publications No. 834. 1961. 7 pp. 5 cents.

This presents the major points to be considered in relation to health education, school environment, and health services in developing or improving a school health program. It also includes a selected bibliography on policies for a school health program.

WHEN YOUR BABY IS ON THE WAY. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 391. 1961. 28 pp. 15 cents.

This booklet gives expectant mothers—and fathers—advice and information on their roles in good prenatal and postpartal care.

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